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Harvard Medical
ALUMNI BULLETIN

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Inside HMAB

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Commencement at Harvard Medical School outwardly celebrates victory, the personal triumphs of those who have struggled against their own limitations to become physicians. The processions and the banners proclaim relief: we survived the ordeal (we happy few, we band of brothers and sisters).

There's little time to savor the respite, though. "Bestow yourself with speed," is what the graduate hears from Class Day speaker Marian Wright Edelman, who powerfully calls for physicians to take sides in the undeclared war against American children. The skills for this particular battle are little developed by medical curricula, indeed are problematic in any such course of study, for they presuppose social values and political commitment, which coexist uneasily with the principles of academic neutrality. Whether neutrality is defensible in the face of such slaughter is a hard question.

The hardest, perhaps, but not the only one. In the past few decades, graduates have sought ways to formulate their commitment they make as they take up this calling. Nathaniel Hupert '94 tells how he and his classmates devised their statement of principles 25 centuries after "Hippocrates." John D. Stoeckle '47 explores the ways in which our profession is being infiltrated by changes, making it ever more difficult to maintain a sense of common cause. And as Margaret Hamburg '83 reminds us, what may seem medically straightforward has been rendered endlessly complex by tectonic changes in the landscape of medical practice. Mitchell Rabkin '55, nevertheless, finds that there are strategies that can help guide us across the treacherous terrain.

After 14 years of good sense, clear vision, and generous-spirited commitment to the *Harvard Medical Alumni Bulletin*, J. Gordon Scannell '40 is passing the baton. One succeeds him with no hope of replacing him—and with no ability to put *tempus fugit* into the past perfect. (Is that what it was, Gordon?) We will continue to rely on him for his knowledge, wisdom and gentle humor.

William I. Bennett '68

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Farewell

Tempus fugitum est

Leaving the editor's easy or uneasy chair, as the case may be, after 14 years is not to be entered into lightly, especially when you found them good years at a time of life when you could enjoy its pleasures. You hope that you have built well on foundations laid years ago by Joe Garland of sainted memory and by a succession of editors you knew and admired, most recently George Richardson '46 and before him John Brooks '43B. And you have stored treasures for the future in what George F. Kennan has felicitously called "the attic of memory."

Mostly, of course, you remember people, a succession of presidents of the Alumni Association and members of the Alumni Council in all their pentads. To them you were officially answerable but rarely called to task. You remember deans—the two deans who generously supported your budgetary needs and once, at least, suffered with you in what can only be called an editorial fiasco. It happened many years ago in the phase of transition. I shall be ever grateful to a third Dan, Dan McCarron, director of the Office of University Publisher at the time, for his publishing skills. He set us on the right track and helped us stay thereon for many years, with Ellie Bradshaw to help with design.

I was fortunate in my editorial boards. Occasionally a port of refuge but principally a source of ideas at the four or five brain-storming sessions we had each year. One member of the board merits special thanks: Gil Sanchez '49 attended regularly all 14 years. His cultivated mind, his humor and wide-ranging interests enlivened our board meetings. He produced a history of the splendid Shattuck succession, and profiles of the eminent French physician Dr. Guillotine and of Boston's own James Michael Curley, patron of Boston City Hospital.

Certain issues stand out in memory. In the early '80s, the dawn of the third century of Harvard medicine leant a strong historical flavor to the *Bulletin* and amplified the Alumni Day affairs, such as grace the current issue. There were other thematic issues: Doctors and Money, the New Pathway (before it became the Common Pathway), Doctors as Patients. Lisa Drew was managing editor in those high and far off times, until she was lured away by other prospects of *Newsweek* and cities to the south of us.

Enter Ellen Barlow, who as managing editor can but I hope will not strike out sentences in her praise. Knowledgeable about the school, buoyant by temperament and skillful as a writer and editor and above all, loyal, she has made the editor's chair an easy one indeed. The succession of issues during the past two of her years here are largely of her making and make evident her skills and interests. For example, the recent issue on health reform and another on creativity. Along the way she enthusiastically abetted my interest in the concurrence of religion and medicine and a commemoration issue on Bill Castle. Then there is my farewell issue on the writers among us, capably managed by Terri Rutter, assistant editor for the past five years and acting managing editor for this issue. And finally we must not forget Sarah Nelson, who cheerfully tended class notes and special profiles. Time not only flies—it has flown—*tempus fugitum est.*

With every confidence I can pass the torch, hand over the reins, drop the pilot or whatever the phrase you choose to Bill Bennett '68, eminently qualified to carry on, and to Ellen Barlow and her team.

Gordon Scannell '40

Letters

A Model Practice

The article by John Stoeckle et. al. (Spring '94) is a thoughtful commentary on HMS and the development of primary care programs. The authors, however, omitted the Harvard Family Health Care program from their review (although it is referenced in a "Pulse" item about the Charles A. Janeway professorship).

The Family Health Care program at Children's had its beginnings in 1956 with the vision of Charles A. Janeway and the leadership of Robert J. Haggerty. The program complemented a similar effort at the Massachusetts General Hospital organized by David Rutstein with clinical leadership at MGH being provided by Fred Blodgett and Joseph Stokes, Jr. Both the MGH and CHMC were experiments in the education of medical students in family medicine. The MGH program ended in 1960; the FHCP continued until 1974.

Not only did medical students and pediatric residents at Children's Hospital learn about primary care, but from 1966 to 1972 the program also operated a residency in family medicine. Dr. Janeway was joined by George Thorn at the Brigham and Duncan Reid at the Boston Hospital for Women in endorsing the residency. Training consisted of one year in medicine at the Brigham, one year in pediatrics at Children's and a third year in the FHCP with continuity at the FHCP through all three years. The FHCP functioned as a model practice similar to what would soon be required in family medicine training programs.

The FHCP was established before the Family Practice Board came into existence in 1969. The FHCP did not satisfy the residency requirements of the new board and ceased to exist in 1973. It is fair to say, as did Stoeckle and colleagues, that family practice

Letters

training was resisted at HMS but it is not correct to say that it was never developed.

As the medical director of the program from 1965 to 1972, I can speak about our attempts to develop a broader constituency for family medicine in the Harvard Medical community. I met with Dean Robert Epert in 1970 about incorporating the Family Health Care program as a teaching unit of the newly established Harvard Community Health Care Plan (HCHP). Dean Ebert's concern at the time was that HCHP was financially insecure and that it needed to become established as a service system before it could consider any teaching role. I hoped to have HCHP enroll the 600 FHCP families and was confident that the teaching costs would be funded by extramural sources. In 1969 the Theodore Schultz Fund awarded approximately $1 million to the FHCP, making it, to the best of my knowledge, the first and at the time the best endowed family medicine program in the United States.

There is a lesson in this story for those who are currently invested in training for primary care at HMS. So long as training for primary care remains an experiment with extramural funding and the larger community is able to "resist primary care training," such work as Dr. Thomas Inui's will end up no different than our earlier efforts. This outcome was true not only at HMS but also at a number of medical schools engaged in experiments in primary care; for example, Cornell, Colorado, Yale and Case Western Reserve.

It may be that what we do in education has little long-term effect. What is important is that the work environment must change and primary care be rewarded professionally, socially and financially. Should the work environment change as part of health care reform, then the change to institutions such as Harvard Medical School would be to educate appropriately to avoid the ongoing mismatch that exists in medical education with its emphasis on hospital-based specialties.

I hope the outcome of today's efforts will be different from our earlier medical education experiments because of substantial change in both the medical school and the society around it.

Joel J. Alpert '56

Family Matters

I am writing in response to the article entitled "Training Grounds for Primary Care" (Spring '94).

After completing medical school at Harvard in 1977, I went on to successfully complete training in Rochester, New York in the discipline of family medicine. In my medical school graduating class there were six students going into this field. I thought the number was pathetically low at the time, and had hoped it would increase. In fact, the number has remained either stable or declined for most subsequent classes. I find this quite disappointing, but not surprising, considering the hostility that Harvard faculty routinely evinced for my career choice while I was there.

If there is now an argument that Harvard doesn't discourage students but rather they make their own career decisions, I would refer you to the 1992/93 course catalog (I haven't seen this year's). Family medicine appears nowhere in the entire list of printed offerings. This absense must make HMS unique around the country. By contrast, of course, there are about a dozen surgical subspecialty rotations well enough defined to warrant a printed description. HMS is one of a small handful of U.S. medical schools with no department or division of family medicine, and no current plans to develop one.

HMS usually claims to be in the forefront of curricular reform (for example, the New Pathway) and a leader in medical education. However, in this area HMS is shamefully delinquent, obstructionist and outdated. The nation is thankfully beginning to recognize that primary care in general and family medicine in particular, is a key piece in the evolution of the health care system towards a more rational and affordable structure that will meet patients' needs better at lower cost. Generating endless supplies of subspecialty surgeons is not a progressive form of education for the needs of the country.

Although the recent increase in interest in primary care at HMS is encouraging, as are Thomas Inui's presence and efforts, I saw no reference to family medicine as a defined and legitimate discipline, nor any statement indicating any interest in developing a family medicine presence at HMS. Our discipline is the quintessential primary care discipline, based on continuity in treating the whole person, within the context of his or her family and community. We effectively coordinate subspecialist referrals and other services when appropriate, and provide comprehensive care for patients from birth to death. Our forte is competently handling more than 90 percent of outpatient illnesses presented to us, as well as the majority of inpatient problems. HMS currently has no effective models of this range of care, unless students seek out their own electives.

Academic family medicine has taken a national leadership role in doctor/patient communication, educational evaluation and teaching modalities, critical examination of

screening, cost-effectiveness of outpatient care, and community-oriented primary care.

I hope that the working groups coordinated by Dr. Inui will be successful in their efforts to develop effective clinical presence, medical school curriculum, mentorship and legitimacy of primary care focus within the traditional departments. I particularly hope that recommendations to develop family medicine at HMS will come from these groups, and that the institution will respond.

Patricia T. Glowa '77

A Solution to Control Costs

Congratulations on the Spring '94 issue of the *Bulletin*—including the chutzpah of the cover—for its outstanding discussion of health care policy. I have been most interested in this subject and think that Harvard Medical School is an appropriate forum for an open discussion.

By allowing the private sector to solve the problems of health care finance and access, the increased costs of the government bureaucracy/health insurance bureaucracy can be drastically cut without affecting care. Only such reform will mean a true reduction of cost of health care while maintaining the health of the nation. This could be accomplished by two changes in the tax code: establishing a Health Savings Account to be financed by individual contributions and a Health Enhancement Tax.

The Health Savings Account would work like an IRA in that yearly funds would be deposited in an interest bearing account and these funds would be nontaxable. Health Savings Accounts would not be taxed on the deposits, interest or withdrawals. The amount contributed each year would be $1,000 plus the median premium of $1,000 deductible catastrophic health insurance policy for essential health services. These contributions would be on an annual basis and would be funded by the employer, the employee or the individual.

Any citizen covered by a federal relief program would be funded by the Health Care Voucher, which is funded by the Health Enhancement Tax (see below). At the age of 65 the individual could decide whether to become a "medical ward of the state" and join Medicare or continue providing his or her own health care insurance through the Health Savings Account. Any accumulated funds could be used to pay the deductibles of Medicare coverage.

The Health Enhancement Tax would tax alcohol, tobacco, gun powder, saturated fat and highway fuels (auto accidents). These items are something the individual can control and, through prudent use, his or her health will be enhanced. They can be looked upon as a premium for a risky lifestyle.

The health insurance industry will compete for the $1,000 deductible catastrophic health insurance in the hopes of attracting customers to supplemental insurance, which could be bought with after-tax dollars. In addition, the insurance industry could compete on the basis of service to enroll as many patients as possible with a guaranteed premium payment. Banks would compete for the Health Savings Account as they would represent a cheap source of funds. They would gladly install the necessary electronics in the doctors offices as well as hospitals and clinics. Security could be maintained with a Health Savings Account Card with picture ID and/or thumb print ID.

The net result would be privatization of health care with the individual able to act as a cost control monitor. The massive bureaucracy of Medicare/Medicaid and the health care insurance industry would be minimal as all but major claims would be eliminated. Medicare would also have to compete for the business of those senior citizens 65 and older.

The marketplace would serve as a control of costs as the individual has a financial interest in the prudent use of funds that will ultimately accrue to him. Thus, two changes in the tax laws—with the formation of Health Savings Accounts and a Health Enhancement Tax— will solve the "health care insurance crisis."

W. Reid Pitts Jr. '67

Mayor Curley and I

The article "The Mayor of Boston City Hospital" (Spring '94) is interesting but touched on only a few matters that proved Curley's leadership. No mention was made of his great concern about Long Island Chronic Disease Hospital in Boston Harbor.

In April 1940, Mayor Tobin appointed me director of that institution. I was most reluctant to accept—the conditions were unbelievable. Health and plant facilities were neglected, deteriorated, unhealthy, dangerous. He promised to correct deficiencies and tried, but World War II prevented further efforts. Doctors, nurses and employees resigned or requested leaves of absence in order to enter military service. Surrounded by island anti-airforce bases in permanent black-out, conditions were bleak and discouraging.

In January of 1945, a few weeks after taking office for the fourth time, Mayor Curley called a meeting of department heads to discuss future plans. Included was a proposal to transfer patients off the island and to abolish the institution. I alone opposed the plan and at the end of the meeting apologized. Within 48 hours, I sent him a 20-page letter outlining the

Letters

opening of the institution in the late 1880s, the condition in which I found it, and what we had accomplished. I added 18 recommendations for major improvement, for the opening of a school for practical nurses, and for the construction of a bridge between the island and the mainland at Squantu. (Boat service was undependable and unsatisfactory.)

He gave no reply but he did accept all my recommendations and proceeded to act on them. He received federal approval for the proposed bridge construction and engaged engineers and architects to make plans. For the first time protection was provided by the Boston Fire Department with new apparatus and assignment of permanent groups of fire fighters. The School of Practical Nursing graduated its first class of 22 students, all of whom received grades of 95 percent or over in state board examinations. The completed bridge was dedicated by Mayor Hynes in 1951.

Mr. Curley visited me often in the mid-1950s when I was assistant director at Boston City Hospital. We reminisced over the transformation of Long Island. On November 5, 1958, he was admitted for acute abdominal surgery. Members of the press remained at the hospital to obtain news of his condition, and the hospital director delegated me to deal with them. Days later, while up and around in the ward corridor, press photographers took our picture together, which appeared in the papers the following day. That night Mayor Curley died.

It was very sad. He was a great humanitarian, a dynamic leader, dedicated to the care of the chronically ill, the aged, the poor and the chronic alcoholics. Of great interest, significance and pride to me is that Mayor Curley was a staunch liberal democrat. I have always been a staunch conservative republican.

James V. Sacchetti '27

The Author Responds

I appreciate the inclusion, in your lovely Summer 1994 issue, of William I. Bennett's reflective review of *Listening to Prozac*. I wonder, though, about one aspect of his reasoning. If the clinical and scientific core of the book—what Dr. Bennett calls "Listening to Fluoxetine"—is "thoughtful, humane, learned, readable" and instructive regarding topics in contemporary psychiatry, doesn't that soundness justify the recounting of the case vignettes in the portion Dr. Bennett calls *Listening to Prozac*? Those vignettes set the stage, for the general reader, for the technical material that accompanies them; reflexively, if the technical portion is accurate (for example, the argument that new psychoactive medications can sometimes change such personality traits as sensitivity to loss or rejection), then the vignettes are worthy of analysis.

Late reviews of *Listening to Prozac*, those that began to appear once the book was a best-seller, have contained reactions as much to the book's popularity as to its content. Reviewers often evince a doctorly reluctance to have controversial issues aired in so open an arena, as if the discussion of innovative ideas, including clinical observation and the synthesis of published research, should be limited to professional forums. Such a rule would impoverish creativity in medicine, especially since our journals tend to be narrow in content. It would also weaken the new, collaborative doctor/patient relationship. I appreciate Dr. Bennett's careful and generally enthusiastic assessment, but like certain other recent notices, it contains the seeds of an odd appraisal: "This is a fine book—if only fewer people would read it."

Regarding the title: I still like, have always liked, *Listening to Prozac*. The poet Donald Hall pointed out to me that, beyond referring to a product that was already a character in the popular imagination, the title contains a peculiar, perhaps subliminal, rhyming pun on "listening to music" and (what is equally to the point) "listening to Muzak." To my ear, "Listening to Fluoxetine" has no music.

Peter D. Kramer '76

Pulse

A Generous Return

In the largest single gift ever given to the medical school—and the eighth largest individual donation ever given to an educational institution in the United States—Leonard and Isabelle Goldenson have donated assets totalling $60 million to fund research on cerebral palsy and the neurosciences.

Leonard Goldenson was one of the visionaries behind American television. He quickly rose to the top of the American Broadcasting Company and established ABC as a leading force in this emerging medium by having the foresight to understand television's potential as an entertainment and information powerhouse. Isabelle is a longtime advocate for the handicapped, particularly in her support of technological advancements that increase mobility for disabled persons. Building B, which houses 30 neurobiology laboratories, will be named after the Goldensons and will undergo extensive renovations to update its facilities.

When Genise, the eldest of the Goldenson's three daughters, was a toddler she was diagnosed with cerebral palsy. Although very little was known about the disease at the time, the couple found support in Sidney Farber and William Berenberg, HMS professor of pediatrics *emeritus*. It was the beginning of an association that was to last for many years.

Their daughter's illness prompted Isabelle Goldenson to embark on an ardent commitment to advocacy for the disabled, which continued after Genise's death in 1973. She and her husband, along with Farber, cofounded the United Cerebral Palsy Fund, which now has 275 clinics; their affiliation also led to the formation of the United Cerebral Palsy Research and Education Foundation at the National Institutes of Health.

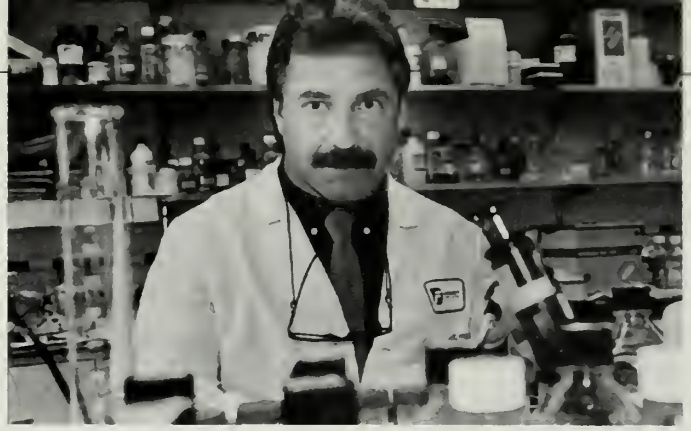
Isabelle also spearheaded projects and ideas that have now become standard fare. In 1973 she persuaded John A. Volpe, secretary of transportation under President Richard Nixon, to authorize parking spaces for the handicapped, resulting in the well known blue and white wheelchair graphic now seen reserving spaces in nearly every public parking lot. She lobbied for a light-weight wheelchair, prompting NASA to develop one made of aluminum instead of steel. And she urged Farber and Berenberg to literally put their heads together with scientists at MIT in an effort to bridge medicine and technology; the result was the creation of the HMS/MIT exchange program for students.

The Goldensons hope to continue this work with their donation to HMS. "We believe it is essential to marry the advances of neurobiology with the needs of cerebral palsy research. We hope our gift will encourage communication and the sharing of medical ideas between Harvard Medical School and the cerebral palsy community."

Photo by Steve Uhlich

Daniel Tosteson with Leonard and Isabelle Goldenson

Pulse



Wayne Marasco

photo by Laura Wulf

Gene Therapy Against AIDS

HIV, the virus that causes AIDS, has a metaphorical arsenal of big guns, sabers and bayonettes that enables it to brutalize crucial immunity-building T cells. In the world of molecular biology, the most vengeful of these weapons is called gp120, and HMS researchers have developed a counterinsurgency plan to hunt it down.

Wayne Marasco, assistant professor of medicine, and others in his lab at the Dana-Farber Cancer Institute are working on a gene therapy program that aims to wipe out the gp120 protein, both inside infected T cells and extracellularly. Without this molecule, Marasco found, HIV is 1,000 to 10,000 times less effective in infecting other cells.

Unlike other viruses, HIV possesses the uniquely pernicious capacity to make copies of itself with amazing efficiency. Once HIV gets inside a T cell, it takes over the cell's reproductive system and rapidly duplicates itself, thus prohibiting the replication of healthy T cells. The virus then leaves the cell and begins a journey through the blood system, infecting other cells—a process that eventually depletes the body's fortress of immune cells.

A year ago, Marasco and his colleagues engineered T cells to express an antibody, dubbed sFv105, which latches onto the precursors of gp120, disenabling it from doing its duplication work. But because sFv105 can't exit the cell, the next step was to find a protein that could not only wipe out gp120 inside the cell but, because some virus particles can escape, could also track the virus wherever it went and destroy it in its path.

Marasco, with post-doctoral fellows Si-Yi Chen, Yousef Khouri and graduate student Jessamyn Bagley, created the antibody that could do such a fabulous thing: Fab105. Fab105, says Marasco, can trail gp120 "all the way through the secretory pathway from the endoplasmic reticulum, just outside the nucleus, through the Golgi complex out to the transport vessels." Even mutations of the virus were inhibited. Their results were published in the June 21 issue of the *Proceedings of the National Academy of Sciences.*

While emphasizing that they have not found a cure for AIDS, Marasco is optimistic about what his research means: "We can attack enzymes the virus needs to take over T cell genes, or proteins needed to give the virus its structural stability. Such antibodies can be given in combination. If each of two of them reduces replication a thousandfold, we might see a millionfold reduction when they are used together."

This work was done in vitro using human cells; Marasco hopes to begin a clinical trial by the end of this year or early next. He is waiting for approval from the National Institutes of Health and the Food and Drug Administration.

Ethical Considerations

Some of the most revered names in medical scientific research gathered at Harvard Medical School in June for a conference dedicated to the question of ethics within today's laboratories. "There is a nostalgia [among scientists] for a past when there was less concern about misconduct, and the privatization of products of research," said Harold Varmus, director of the National Institutes of Health and one of the speakers. "Science seems more complicated today and less fun."

Entitled "Issues in the Conduct of Research: What is Happening to American Science," the day-long symposium was sponsored by the Division of Medical Ethics, the HMS Department of Neurobiology and the Charles A. Dana Foundation. It is a component of the Harvard Program in the Practice of Scientific Investigation, part of a response to the NIH mandate that postdoctoral fellows and graduate students receiving National Research Service Awards attend an instructional program on the responsible conduct of research.

Ruth Fischbach, co-director of the Program in the Practice of Scientific Investigation and assistant professor of social medicine, chaired the planning committee for the event that included Linda Emmanuel '84, assistant professor of medicine; Gerald Fischbach, Nathan Marsh Pusey Professor of Neurobiology; Lynn Peterson, associate professor of surgery and associate professor of medical ethics in the Department of Social Medicine; and Huntington Potter, associate professor of neurobiology. Panels explored two

Jamela Franklin

photo by Steve Gilbert

major areas of concern within today's research environment: personal responsibility of the scientist and the sometimes uneasy relationship between academia and industry.

Marcia Angell, editor of *The New England Journal of Medicine*, moderated the morning panel on Big Science vs. Small Science: The Ethics of Personal Responsibility. Arnold Relman, professor of medicine emeritus, pointed to a rising distrust of science: "There is a powerful anti-science mood in the land these days."

The conference comes in the wake of several highly publicized cases of scientific misconduct, including that of a multicenter study of breast cancer that contained deliberately falsified data; and the debate over whether AIDS researcher Robert Gallo misused a vial of virus from France to make his discovery of HIV. As Relman said "There is a great deal of cynicism."

Another issue facing research today is its love-hate relationship with industry. In light of reduced funds from the government against the ready money from the private sector, academia and industry are making tenuous alliances to push scientific discoveries into marketable products. While on the one hand, these partnerships might result in beneficial drugs and other products, they could also create conflicts of interest and replace scientific inquiry in its purest sense with more monetary motivators.

"Has technology transfer changed the nature of academic research? Does it subvert, pervert academic values?" asked Christopher Walsh, Hamilton Kuhn Professor of Biological Chemistry and Molecular Pharmacology. "We need to know the potential for conflicts."

In her keynote address, Sissela Bok, distinguished fellow at the Harvard School of Public Health spoke of the need for trust between society and scientists. "Trust is a totally crucial ingredient in a social environment," she said. In an analogy of trust to oxygen, Bok said that too much causes fires, while too little leads to death. "Trust is a public good, like air or water, much easier to destroy than to create and revise."

In order to keep the discussion and the study of ethics an ongoing component of scientific research, the Division of Medical Ethics, with funding by the Dana Foundation, has established a Responsible Conduct of Research Award in the form of a $500 certificate for books. It was awarded during a luncheon presentation to Lee Baer, associate professor of psychology and director of the obsessive-compulsive disorders clinic at Massachusetts General Hospital.

HMS Awarded for Major Minority Efforts

Harvard Medical School has received the American Medical Student Association's 1994 Paul R. Wright Excellence in Medical Education Award for its recruitment and retention of underrepresented minority students. The award was presented in March at the AMSA's national convention in Arlington, Virginia.

Last year African-Americans, Mexican-Americans, Puerto Ricans and Native Americans made up 19 percent of the entering class, up from 14.8 percent in 1988. The Office of Recruitment and Multicultural Affairs (ORMCA) was established 25 years ago in the wake of Martin Luther King Jr.'s assassination. Since that time about 575 minority students have graduated from HMS.

Jamela Franklin, associate director of the recruitment program, describes the goal of her office: "To increase the number and retain underrepresented students in medicine. The office has successfully recruited students in attendence at historically black colleges, city colleges and community colleges."

Pulse

Arthur Lee and Jerry Tsai

photo by Barbara Steiner

Few Are Chosen

Three Harvard Medical School faculty have been given one of the highest honors that can be accorded an American scientist: election to the National Academy of Sciences. A fourth faculty member is the recipient of an NAS award in molecular biology.

The three newly elected members are: Frederick W. Alt, professor of genetics and pediatrics, for major contributions he has made to cancer biology and immunology; Frederick M. Ausubel, professor of genetics, for his landmark studies of signal transduction in bacterial and plant cells; and Mary Ellen Avery, professor of pediatrics, who has been a pioneer in the treatment of premature and low-birth-weight babies. Jack Szostak, professor of genetics, who was honored for his work on ribozymes, won the molecular biology award, which he shares with Gerald Joyce, an associate professor at the Scripps Research Institute.

Inducted into the NAS were Edward Harlow, professor of genetics; Peter Howley '72, chair of the pathology department; and Joseph Murray '43B; professor of surgery *emeritus*.

New Risk Factor for Heart Disease

Brigham and Women's Hospital cardiologist Arthur Lee answered a question HMS students posed to him by conducting research that has illuminated the mechanism of a newly uncovered risk factor for heart disease.

In making rounds, Lee asked the two students present why a 39-year-old woman who did not smoke, excercised regularly and had a healthy diet could suffer severe hardening of the arteries and blood clots. His answer was because of an amino acid called homocysteine; but when they in return asked him how homocysteine raised the risk of heart disease, Lee said he didn't know. Returning to his laboratory, Lee searched the medical literature and, intrigued by recent studies linking high levels of homocysteine to heart attacks, set out to investigate how and why.

He and his colleagues in the Cardiovascular Biology Laboratory at the Harvard School of Public Health found in cultured cell studies that homocysteine damages the arterial wall in two ways. It spurs the proliferation of smooth muscle cells, a major component of atherosclerotic plaque, and it inhibits regeneration of blood vessel endothelial cells, which are known to protect against the development of atherosclerosis. Their findings were published in the July 5 issue of *Proceedings of the National Academy of Sciences*.

If verified, these results would help explain why a 1992 study led by HMS Associate Professor Meir Stampfer, based on data from the Physicians Health Survey of 15,000, found that physicians with the highest levels of homocysteine were 3.4 times more likely to have a heart attack. Extrapolation from results of the Framingham study, which has followed more than 5,000 people since 1948, indicate that about 21 percent of all older people (and perhaps younger ones as well) in the United States have high levels of homocysteine.

Potentially a lot of people could be helped by more information on this little-known amino acid, which when elevated, says Lee "can be successfully treated with supplements of folic acid, B12 and B6, all known to be involved in the metabolism of homocysteine."

There are many more molecular questions surrounding this amino acid that Lee hopes to investigate. They don't know why, for example, homocysteine inhibits the growth of endothelial cells, but promotes the growth of smooth muscle cells. Or why those vitamin deficiences lead to elevated homocysteine, or what other causes are.

He does suspect, however, that homocysteine is an independent risk factor—just as cholesterol is—for heart disease. If the case for it can be built, screenings for homocysteine may be done just as routinely as for cholesterol and "something as inexpensive as vitamin supplements could prevent a lot of suffering and deaths."

On the Quadrangle

Building a Community of Researchers

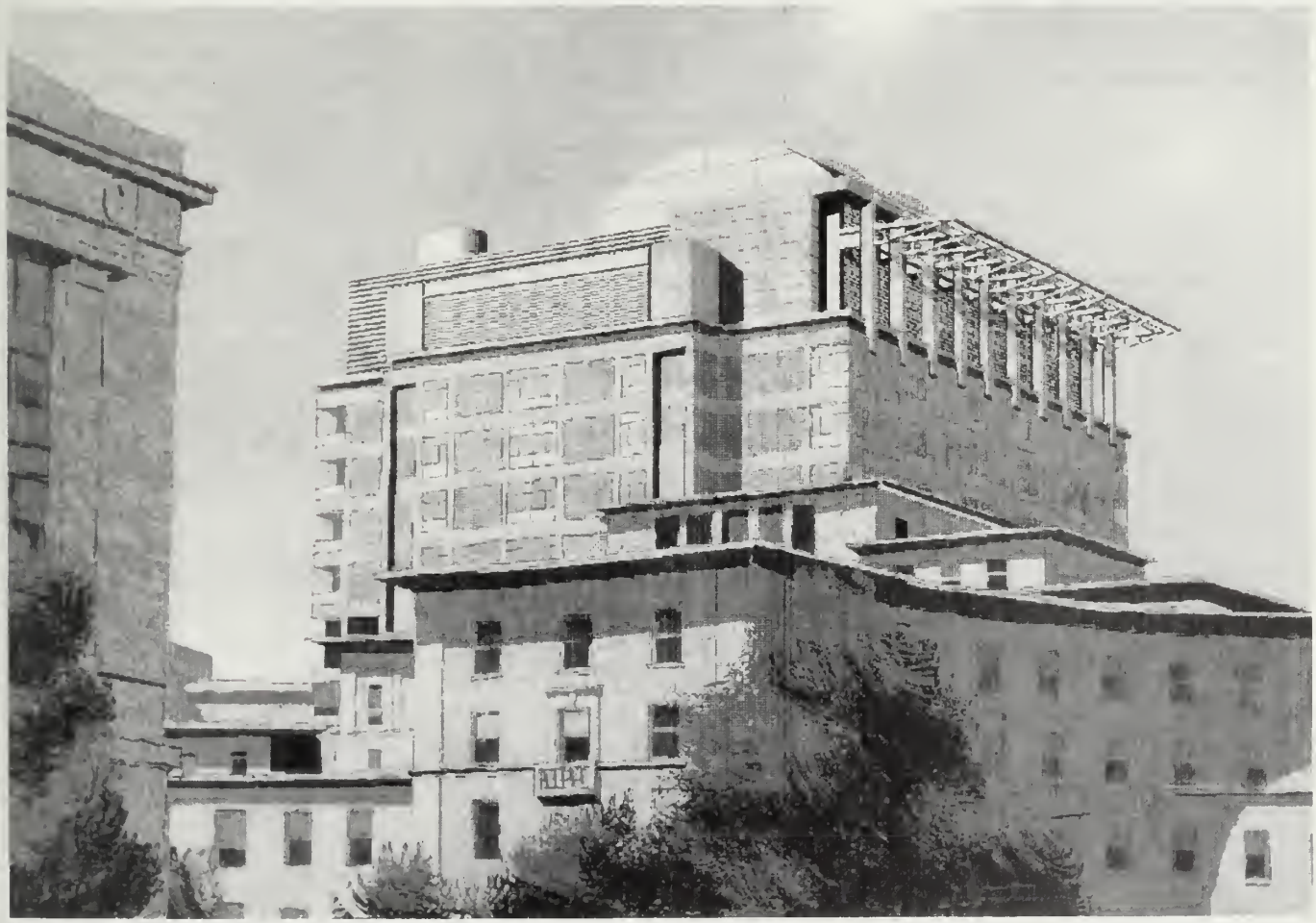
The once Boston English High School, located behind Vanderbilt Hall, will house the future Harvard Institutes of Medicine. Not to be confused with the Institute of Medicine in Washington, the HMS version, in fact, is closer in concept to the institutes of the National Institutes of Health. The brainchild of Dean Daniel Tosteson '49, the Harvard Institutes of Medicine will be "interdisciplinary, inter-institutional, and programmatic in the NIH sense."

For $12 million, Harvard Medical School purchased the three-acre site of the old Boston English High School, which had been vacant since 1988 when the school moved to Roxbury. Renovation of the school's 10-story tower—expected to cost another $78 million—began this summer. Starting March 1996, its research occupants will start to move in: four floors are to be leased to Brigham and Women's Hospital, three floors to Beth Israel, one probably to the Deaconess, and two to be devoted to two of the three or so planned Harvard institutes.

Slated for the two HMS floors are the Institute for Human Genetics, with Phil Leder '60 as faculty director, and the Mind, Brain, Behavior Institute, to be directed by Steve Hyman '80. Although it is not clear how these institutes will be structured, says Ann Schwind, administrative dean for planning and corporate relations, they will be research-oriented. The idea is to have both basic scientists and clinical researchers communicating and cooperating, coming at a common problem from different perspectives.

To facilitate interactions among the investigators in the building, there will be a shared seminar room and cafeteria on the first floor. And what had been a concrete plaza facing Avenue Louis Pasteur will be landscaped with grass and benches to be a more attractive public space. Since the concept is for this to be "a community of researchers," as the dean calls it, researchers will participate in planning all aspects of how the building and its support services will function—security, environmental health and safety policies to such aspects as provisions for biopolymers and glass-washing.

Originally there was a great deal of talk (and publicity) about the dean's intention to lease space to corporations with compatible research pro-



An artist's rendition of renovated building behind Vanderbilt.

On the Quadrangle

jects. Through greater industry academic collaboration, it was hoped, research results could more speedily be transferred to the marketplace and thus more efficiently help the sick.

As it turns out, in this phase of the new site's development there probably won't be any corporate tenants, says Schwind, although there are some companies interested in sponsoring research in the institutes. The reason is simply because there was a great demand for space by Harvard programs and "some of the companies wanted a lot more space than we could make available."

In a future phase of development, however, the site of a smaller building that had housed a swimming pool and auditorium, which was in disrepair and has been torn down, may be developed and could conceivably house corporate ventures. In the meantime, that area will be used for parking, another much coveted use of space.

Though students living in Vanderbilt may have to put up with constructive disturbances, eventually the campus will have a more attractive neighbor in what is becoming an even more vibrant biomedical research and education community.

Ellen Barlow

An Editor is Welcomed

The new editor of the *Harvard Medical Alumni Bulletin* is William Ira Bennett '68, "as close to the ideal as one could ask for," announces Dean Daniel D. Federman '53, director of alumni relations and chairman of the search committee. His appointment marks the end of a surgical dynasty at the *Bulletin.* Bennett, a psychiatrist, succeeds three surgeons: J. Gordon Scannell '40, who just retired after 14 years as editor, George S. Richardson '46 and John Brooks '43B.

"Bill Bennett brings a complementary expertise—internal medicine and psychiatry," says Federman, "and since he recently re-trained in a psychiatry residency, he is able to understand the experiences of younger alumni."

Even more pertinent to a publication, he is an experienced editor and writer. He was editor of the *Harvard Health Letter* for eight years until 1991, having started at that publication in 1979 as associate editor with Timothy Johnson, who is now medical editor for ABC-TV. Bennett has been an editor for science and medicine at Harvard University Press, lecturer and then director of MIT's writing program, and a writer and advisor for Metromedia Production's "Healthbeat Magazine."

Bennett, a graduate of Harvard College (1962) as well as the medical school, was president of *Harvard* magazine from 1978 to 1986. He has written over 30 articles for that magazine as well as for the *New York Times Magazine, Vogue, American Health, Science 80* and *82,* the *Atlantic,* the *Boston Phoenix* and the *Washington Post.* He is co-author with Joel Gurin of *The Dieter's Dilemma: Eating Less and Weighing More* (Basic Books, 1982).

His professional career has been an alternating one, from medicine and research at the National Institutes of Health, to a full-time career in medical

photo by Barbara Steiner

communications, and now back to medicine. "Despite my best efforts, however, my identity as a physician never went away," he quipped, "and that continuity I've come to cherish."

Twenty-one years after completing an internship in medicine at Boston's Beth Israel Hospital, he went back to do a residency in psychiatry at Massachusetts Mental Health Center, which he completed this year. Overnight he went from being an HMS lecturer to a clinical fellow. He had to revive old skills, he says, such as how to do a physical examination. "I was astonished at how much I had retained; it really is in some ways like riding a bicycle," he told his classmates at reunion last year in a talk entitled "Second Childhood." Other techniques necessitated some adaptation with the passing of time; he now has to take his bifocals into account when using the otoscope.

Though faced with another new role this year—as attending psychiatrist at Cambridge City Hospital—Bennett couldn't say no when asked to direct HMAB. It is a publication he admires, he says, because it stays close to its readers. "With medical school, we enter a community that in many ways becomes the most important in our lives. This is a fascinating institution and for most of us, HMAB is the window we still have to it."

Ellen Barlow

President's Report

by Robert J. Glaser

A year passes in a hurry! It seems as if I had just begun my year as president of the HMS Alumni Association and yet I have already concluded my term. We are in an interesting, albeit complex, period in medicine and medical education, and those of us serving on the Alumni Council have had the opportunity to learn a great deal about the current problems and challenges for the HMS leadership. As I reported in my first two communications, we have had informative sessions with Deans Tosteson '49 and Federman '53 and their colleagues, at which time we were provided with detailed pictures of the school's many activities in teaching, research and patient care.

As I write this, it is still not clear whether major health care legislation will be enacted by the Congress. No matter what the outcome of the current frenzied debates, there will inevitably be an impact on medical schools and their teaching hospitals. Our academic medical centers must accommodate to the changing medical care scene, but we hope that the powers that be will recognize the special needs of these organizations, which collectively constitute an invaluable national resource.

I personally believe that our health care system can be improved in various ways—for example, by an orderly correction in the imbalance between specialists and generalists—but it won't be easy, and almost certainly won't be accomplished by draconian measures. Further, it is essential that there be continued adequate support of medical research, which has contributed so much to the quality of medicine in the years since World War II.

A number of the topics addressed by the council at its last meeting on June 8, 1994 were pertinent to the foregoing comments. We received a detailed report on the internship choices of the Class of 1994, which showed a distinct increase in the number of graduates selecting internal medicine, a reversal of recent trends. The training of generalists was discussed by Thomas Inui, professor and chairman of the relatively new Department of Ambulatory Care and Prevention.

Additional reports were presented on the continuing need for financial resources to maintain the quality of HMS programs; special emphasis has been focused on ways to ease debt burdens of medical students. As is by now widely known, the university has embarked on a $2.1 billion campaign in which HMS will take part. The school's goal over the campaign's five-year duration will be $200 million.

On Tuesday evening, June 7, a very pleasant ceremony took place on the third floor of Building A to dedicate the Alumni Council Room. Its walls now are adorned with the photographs of the past chairs of the Alumni Fund, past editors of the *Bulletin*, and past directors of the Alumni Association. In the spacious atrium on the third floor, a wonderful collection of photographs and exhibits detailing the medical school's history has been assembled; alumni will find a visit to the area a pleasure.

A sad event late in the academic year was the death of Doris Rubin Bennett, a member of the Class of 1949, the first to include women. Dr. Bennett, a devoted and highly respected pediatrician, served with distinction as chairman of the Alumni Fund and she will be greatly missed. A celebration of her life was held at the school late in June.

As I noted in my first report, Gordon Scannell '40, who guided the *Alumni Bulletin* as its editor in such an admirable and effective way for more than a decade, indicated his intention to retire at the end of the 1993/94 academic year. Happily, the search committee was able to identify a very worthy successor, William I. Bennett '68. Dr. Bennett, a psychiatrist based at the Cambridge Hospital, is himself a gifted writer, and we are all delighted that he will take over for Dr. Scannell, to whom we are greatly indebted.

Finally, Alumni Day on June 10 was a most pleasant occasion and the weather was ideal. Chester D'Autremont of the 50th-year class of 1944, and George Thibault of the 25th-year class of 1969 presented Dean Tosteson with their generous class gifts, after which I had the pleasure to present the Alumni Council gavel to my successor, John Stoeckle '47, professor of medicine at Massachusetts General Hospital and one of the most respected physicians and teachers on the HMS faculty.

Alumni Day concluded with an excellent symposium in which the participants were John Stoeckle, Margaret Hamburg '83, Mitchell Rabkin '55 and Nathaniel Hupert '94. A large and enthusiastic audience actively participated in the discussions that followed the several presentations.

It only remains for me once again to express my appreciation for the privilege of serving as president of the association. I particularly want to reiterate my thanks to Nora Nercessian, the association's executive director, for her invaluable support, without which the council and its officers would find the discharge of their responsibilities a harrowing if not impossible task!

Robert J. Glaser '43B is a trustee and director for medical science of the Lucille P. Markey Charitable Trust and consulting professor of medicine at Stanford University. He is former dean of two medical schools, Stanford and the University of Colorado.

Class Day

THE QUAD WAS ALIVE WITH THE sound of music as the Class of 1994 descended on it for Class Day. An elegant backdrop during the luncheon was a string quartet and a wind quintet from the HMS Music Society playing the chamber music of Mozart and Beethoven. Then with a change to the dramatic, the rousing chords of the themes from blockbuster movies Rocky and Star Wars moved the graduates to their seats during the procession.

Student co-moderators Paul Allen and Rebecca Baron kept up the beat. In a ping-pong repartee of puns and jokes that had their classmates alternately groaning and laughing, this comedic duo guided everyone through the welcome, introductions of speakers, to final parental salutations. Baron captured the moment for prosperity by photographing her classmates.

The funning was calmed, however, and a weighted hush descended on the audience, who listened with rapt attention when keynote speaker Marian Wright Edelman, founder and president of the Children's Defense Fund, began speaking. With a voice both demanding and pacific, she spoke of the unspeakably horrific, and yet horrifically common.

"The problem of violence is tearing community and families apart and is becoming a major health concern," she said. Since 1968, the year Robert Kennedy was assasinated, "800,000 American men, women and children have been killed by guns. Another 520,000 have died violent deaths by other means in America's undeclared 20th century civil war."

Edelman called upon all of us, not just the liberal few, to take responsibility for the violence that was eating our society and most profoundly destroying our youth. "The plain truth is, we have not valued millions of our children's lives, and so they have not valued ours," she said. "It is adults who have to stand up and be adults and accept our responsibility to parent and protect the young."

Student speaker Matthew Davis broke the silence, again with music, but this time of a spoken variety. An accomplished musician, he described the "Music of Health" in a one-man acapella song, uh, speech: "An ear for the music that each person produces./And it's not just to words that this music reduces—/It's a crack in their voice, the slope of their shoulders,/ A bruise 'round her eye, the way he grows older./ For every patient we hear, there's a tune unique:/ The flow of each melody is what we can seek."

Vanessa Smith blended humor with insight in her reflection of what qualities one needs to be a physician. Unanimously, she said, her classmates seem to agree that one must like science, but also, one must like people. Beyond that, "We must be relentless in our intellectual commitment," and also strive to develop the quality of compassion, which is different from liking people or offering sympathy or pity. "It is the recognition of our privileged and precious role as physicians in one of the most fundamental of human experiences."

Breaking from routine, the Allen and Baron duet replaced solemnity with pop music in their presentation of faculty awards. The tune "Every Breath You Take" by Sting accompanied Steven Weinberger '73, associate professor of medicine, as he ascended the stairs to receive the award for preclinical teaching. Leslie Fang, assistant professor of medicine and acknowledged for clinical teaching in the third and fourth years, was serenaded with the number "Listen to What the Man Says" by Paul McCartney; and for doing the most for the class, Edward Hundert '84, associate dean for student affairs, accepted his award to the tune of, most appropriately, "You've Got A Friend" by James Taylor. Since Hundert has won this award so many times, the Class of '94 economized by presenting him with a plaque with several empty gold bars so successive classes could just engrave the year.

The class observed a moment of silence for revered faculty member Peter Hess, professor of cellular and molecular physiology, who died last year.

Having rejected the options available to them for an oath, the class

David Altschuler

Angela Fowler and Alphonso Brown talk following Class Day ceremonies.

stood to swear itself into the practice of medicine with one of its own. Their words, written well beforehand, seem to presage those of their invited speaker, making a strong statement about the physician's role in a troubled society: "I recognize that I have responsibilities to my community: to promote its welfare and to speak out against injustice." (For the complete text of the oath, see page 43.)

Bamidele Fayemi-Kammen

"We are proud of each one of you," said Dean Daniel Tosteson '49 in his address. Noting that today's physicians must be prepared to adapt to changing forces and trends in medicine, he congratulated the class for its unique physician's oath "with themes and values that recognize the individual practitioner's responsibility to patients, the profession and the community."

The Class of 1994 filled more chairs before the podium than any other in HMS history—a total of 189 received the MD degree on June 9. This prodigiousness was produced by the increasing number of students who take time to pursue other degrees or to do research before graduating; 41 of the day's graduates earned either a doctoral degree in philosophy or a master's degree in public health, public policy, medical sciences or philosophy. Twenty students graduated cum laude and seven graduated magna cum laude. The recipients of special awards are:

Wendy S. Armstrong, cum laude "Evaluation of MHC Expression Xenografts of Human Neural Cell Lines."

Nicholas Boulis, magna cum laude Harold Lamport Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: "Endogenous Neurotrophic Factors of the Goldfish Optic Nerve."

Alphonso Brown, cum laude "The Human Gamma Globin Gene Promoter from -203 to -194 forms Stable DNA triple helices with Target Oligonucleotides at Physiologic pH and Temperature."

Edward F. Chan, cum laude "Introduction and Expression of the E. Coli Beta-Galactosidase Gene in Miniature Swine Keratinocytes."

Matthew M. Davis, cum laude New England Pediatric Society Prize: "Music as a Means of Public Health Education Among Guatemalan School Children."

Carey Farquhar, cum laude "Influence of Reproductive Steroid Hormones on HIV-1 Replication In Vitro."

Michael J. Fisher, cum laude "Abnormal Growth of Erythroid Progenitors in Polycythemia Vera and Primary Familial and Congenital Polycythemia: Is there a Role for Erythropoietin Receptor?"

Alice W. Flaherty, magna cum laude "Contributions of Motor and Somatosensory Cortex to Movement Control in the Primate Striatum."

Angela Fowler, cum laude "Expression cDNA Cloning of a Transforming Gene Encoding the Human Proliferating Cell Nucleolar Antigen P40."

Evelyn Gonzalez, magna cum laude "Development of Angiogenesis Models and In Vivo Studies of Angiogenesis Inhibitors: Mechanisms and Therapeutic Strategies."

Jeffrey A. Guy, magna cum laude "The Long Term Effects of the Bisphosphonate Alendronate on the Mechanical and Physical Properties of Bone in the Estrogen-Deficient Rat."

Mahalakshmi K. Halasyami, cum laude "Alcohol Use and Domestic Violence in the Lives of Urban Women in South India."

Andrew C. Hecht, magna cum laude "Degradative Enzymatic Systems in Articular Cartilage: The Purification, Characterization and Role in Matrix Degradation of a Novel Serine Proteinase Isolated from Mammalian Articular Cartilage."

Nathaniel Hupert, cum laude Rose Seetal Prize for the best paper on the relation of the medical profession to the community: "A Case Study Demonstrating the Value of Qualitative Methodology in the Evaluation of Ethics Consultations."

Seth J. Karp, cum laude James Tolbert Shipley Prize for excellence and accomplishment in research: "Cloning and Characterization of the Human NMDA Receptor."

Rainu Kaushal, cum laude "Characterization of Betacellulin: A Novel Mitogen from Pancreatic Beta Cell Tumors."

Thomas Kerrihard Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation or scholarship in psychiatry.

Steven P. Leon, cum laude "The Prognostic Significance of Angiogenesis in Patients with Glial Brain Tumors."

Vincent Li, cum laude "Studies of Angiogenesis in Human Cancers: Detection, Activity and Clinical Implications of an Angiogenic Factor (bFGF) in the Body Fluids of Cancer Patients."

Otto S. Lin, magna cum laude Richard C. Cabot Prize for the best paper on medical education or medical history: "The Reinvention of Autointoxication: An Historical Analysis of the Autointoxication Concept in the United States."

Benjamin D. Medoff, cum laude "Expression of Endothelial-Leukocyte Adhesion Molecules in Atherogenesis."

Richard J. Miller, cum laude "The Effect of Injury on Metastasis and Local Recurrence: an Experimental Model."

Tessa Hadlock applauds her way to a degree.

Samuel M. Moskowitz, magna cum laude Leon Reznick Memorial Prize for excellence and accomplishment in research: "Molecular Genetics of Mucopolysaccharidosis I (Hurler's and Scheie's syndromes)."

Elizabeth M. Mutisya, cum laude "Changes in Oxidative Phosphorylation are Associated with Aging and Alzheimer's Disease."

Anju Nohria, cum laude "Expression and Delivery of Interleukin-1-Receptor Antagonist."

Wendell C. Ocasio, cum laude "Analysis of Fluctuations in Heart Rate and Blood Pressure."

Sung-Yun Pai, cum laude New England Pediatric Society Prize: "Inhibition of Calcineurin Phosphatase Activity in Bone Marrow Transplant Patients Treated with Cyclosporin A."

Melanie Ryan-Graham Henry Asbury Christian Award for notable scholarship in studies or research.

Mary P. Wu, cum laude "In Vivo Versus In Vitro Degradation of Controlled Release Polymers for Brain Tumor Therapy."

Janice Blanchard, Gina Moreno, Diana Rodriguez, David Rogers and Sara Szal Community Service Award

John Brooks, Jon Hyman, Gina Moreno, James Oliver and Terri Pickering Multiculturalism and Diversity Award

Cease Fire!

Stopping the War Against Children

by Marian Wright Edelman

"For what shall it profit a man, if he shall gain the whole world, and lose his own soul?"
Mark 8:36

"Not by might, nor by power, but by my spirit, says the Lord of hosts."
Zachariah 4:6

Whoever receives one such child in my name receives me: but whoever causes one of these little ones which believe in me to sin, it would be better for him to have a great millstone fastened round his neck, and to be drowned in the depth of the sea.
Matthew 18:5-6

On April 5, 1968 in Cleveland, Ohio, following Dr. King's assassination, Robert F. Kennedy spoke about "the mindless menace of violence in America which again stains our land and every one of our lives."

"It is not," he said, "the concern of any one race. The victims of the violence are black and white, rich and poor, young and old, famous and unknown. No one, no matter where he lives or what he does, can be certain who will suffer from some senseless action of bloodshed. And yet it goes on and on and on in this country of ours."

Since Robert Kennedy spoke those words, he and 800,000 American men, women and children have been killed by guns. Another 520,000 have died violent deaths by other means in America's undeclared 20th century civil war.

Between 1979 and 1991 almost 50,000 American children were killed by guns. More American children died from firearms on the killing fields of America than American soldiers died on the killing fields of Vietnam.

From 1968 through 1991, when more than 1.3 million Americans died violently at home, 31,000 American soldiers died in military conflicts in other countries. Americans were 42 times more likely to kill each other than to be killed by an external enemy.

This quarter-century death toll of American against American—and of Americans who, unable to face life or find love, hope, purpose or safe haven in their family, community, faith or democratic civic life, took their own life—is almost three times the number of reported American battle deaths in all of the wars in the 20th century.

Gun violence is not just an inner-city black problem. Approximately half of the 316,496 gun homicide victims between 1968 and 1991 were white (158,738) and half were black (157,738), and 93 percent of the 346,225 gun suicide victims were white. Most murders are committed not by strangers but by family members, neighbors or acquaintances.

The morally unthinkable has become normal as the killing of innocent children has become routine, not only in Bosnia and Brazil but in Boston and Baltimore. Twenty-five American children—the equivalent of a classroomful—are murdered every two days as the crisis of children having children has become the greater tragedy of children killing children. An American child is 15 times as likely to be killed by gunfire than a child growing up in Northern Ireland.

Homicide is now the third leading cause of death among children 5 to 14 years old, the second leading cause of death among youths and young adults 10 to 24, and the leading cause of death among black teen males. More young black males are killed by guns each year than from all the lynchings throughout American history.

Escalating violence against and by children and youth is no coincidence. It is the cumulative, convergent and heightened manifestation of a range of serious and too-long neglected problems. Epidemic child and family poverty, increasing economic inequality, racial intolerance and hate crimes,

pervasive drug and alcohol abuse and violence in our homes and popular culture, and growing numbers of out-of-wedlock births and divorces have all contributed to the disintegration of the family, community and spiritual values and supports all children need.

Add to these crises easy access to deadlier and deadlier firearms; hordes of lonely and neglected children and youths left to fend for themselves by absentee parents in all race and income groups; gangs of inner city and minority youths relegated to the cellar of American life without education, jobs or hope; and political leadership over the 1980s that paid more attention to foreign than domestic enemies and to the rich than the poor, and you face the social and spiritual disintegration of American society that confronts us today.

Rob Gipe and his daughter Kelsey make their way through the line of society masters.

Where are the family values in the richest nation on earth when 1 in 5, or 14.6 million of its children, lived in poverty in 1992—5 million more than in 1973? What does national security mean to the estimated 3 million children who witness parental violence every year and the children reported abused and neglected every 13 seconds? How can we expect the 100,000 children who are homeless every night to respect the homes and property of others?

I wonder how many of the 15-year-old murderers today are children who were born without adequate prenatal care and nutrition because our nation said we could not afford to give them a Healthy Start? How many 16-year-old teen mothers having babies today entered school not ready to learn because we would not insist on a quality Head Start for them? How many 18-year-old murderers witnessed and suffered abuse and neglect at home from parents who themselves never were nurtured, taught to parent or enabled to work? How many 19-year-old youths abusing and pushing drugs today are children who saw the adults in their lives abusing or pushing drugs and who lacked positive community alternatives to dysfunctional families and dangerous streets after school, on weekends and during idle summer months?

We have not valued millions of our children's lives and so they do not value ours in a society in which they have no social or economic stake or sense of community. Countless youths are imprisoned by lack of skills in inner-city neighborhoods where "the future" means surviving the day and living to age 18 is a triumph. Their neglect, abuse and marginalization by parents, schools, communities and our nation turned them first to and against each other in gangs, and then against a society that would rather imprison than educate and employ them. Our market culture tells them they must have designer sneakers, gold chains and fancy cars to be somebody, while denying them the jobs to buy them legally. So they are easy marks for drug dealers and profit-driven gun manufacturers and sellers in pursuit of new markets for their lethal products. While the number of children and youths victimized by violence has soared, so has the number of youthful offenders. For murder and nonnegligent manslaughter between 1982 and 1991, juvenile arrests rose 92.7 percent.

There is no excuse for youth or adult crime. Perpetrators must be swiftly and fairly punished. We must stop the ridiculous and simplistic political extremes and deal with our communal complexities—supporting both early investment in children, mentoring and counseling programs, and measures to control guns and ensure safe streets.

But there also is no excuse for the unbridled trafficking in nonsporting handguns, assault weapons and ammunition. A gun is produced in America every 10 seconds and is available to almost anybody who wants to own or rent one, including children. One advertisement encouraging parents to buy guns for children asks: "How old is old enough?" It concludes:

"Age is not the major yardstick. Some youngsters are ready to start at 10, others at 14. The only real measures are those of maturity and individual responsibility. Does your youngster follow directions well? Is he conscientious and reliable? Would you leave him alone in the house for two or three hours? Would you send him to the grocery store with a list and a $20

bill? If the answer to these questions or similar ones is 'yes' then the answer can also be 'yes' when your child asks for his first gun."

More than 200 million guns are legally in the hands of Americans. There are more gun dealers than gas station owners in America. You often can get a license to sell guns more easily than a driver's license and can buy a gun as readily as a toaster across the counters of some of our largest chain stores. Although our nation regulates the safety of countless products including children's teddy bears, blankets, toys and pajamas, it does not regulate the safety of a product that kills and injures tens of thousands of children and other citizens each year.

Our failure to control the proliferation of arms and to confront the plague of violence that transcends all racial, geographic and income boundaries has contributed to escalating community and domestic violence and to its lethality. All the moral thresholds of war have disappeared in Rwanda, Sarajevo and San Francisco as innocent civilians—old and young alike—are slaughtered by indiscriminate gun violence. Even a mother's womb no longer shields babies against violent assault. A Detroit pediatrician wrote: "We have seen 22 pregnant adolescents with gun shot wounds in two small inner-city hospitals in Detroit in 1993."

Violence romps through our children's playgrounds, invades their bedroom slumber parties, terrorizes their Head Start centers and schools, frolics down the streets they walk to and from school, dances through their school buses, waits at the stoplight and bus stop, lurks at McDonald's, runs them down on the corner, shoots through their bedroom windows, attacks their front porches and neighborhoods, strikes them or their parents at home, and tantalizes them across the television screen every six minutes. It snatches away their family members at

Diana Rodriguez and a friend walk in the procession together.

work, and at random. It saps their energy and will to learn, and makes them forget about tomorrow. It nags and picks at their minds and spirits day in and day out, snuffing out the promise and joy of childhood and of the future.

Inner-city children as young as age 10, psychiatrists and social workers report, think about death all the time and even plan their own funerals. Young black and brown men speak longingly of reaching the ripe old age of 20 in their bullet-ravaged, job-destitute, politically forsaken neighborhoods. Some speak wistfully of prison with "three hots and a cot" as a safer haven than their dead-end streets and empty, jobless futures in a society that has decreed them expendable.

James Garbarino, president of the Erikson Institute, says American inner-city children are exposed to such heavy doses of extreme violence, they exhibit symptoms of post-traumatic stress disorder like children in war torn countries such as Mozambique, Cambodia and Palestine.

At least 13 children die daily from guns and at least 30 other children are injured every day, adding billions to our out-of-control public health costs. The National Association of Children's Hospitals and Rehabilitation puts the average child gun-injury hospitalization cost at $14,434.

Although the threat of violence hovers most heavily over inner cities, it respects no boundaries as the madmen shootings, on the Long Island commuter train, downtown San Francisco office building, and Waco tragedy attest. Violence was the top worry of parents and children, according to a 1993 *Newsweek*-Children's Defense Fund poll of 10- to 17-year-olds and their parents.

What do we do? First, recognize that we face a total breakdown in American values, common sense, and parent and community responsibility to protect and nurture children.

Never has America permitted children to rely on guns and gangs rather than parents and neighbors for protection and love, or pushed so many children into the tumultuous sea of life without the life vests of nurturing families and communities, challenged minds, job prospects and hope.

Never have we exposed children so early and relentlessly to cultural messages glamorizing violence, sex, possessions, alcohol and tobacco with so few mediating influences from responsible adults. And never have we experienced such a numbing and reckless reliance on violence to resolve problems, feel powerful or be entertained. A single trip to the movies often results in the witnessing of multiple deaths on a scale that makes them seem irrelevant. *New York Times* movie critic Vincent Canby counted 74 dead in *Total Recall*, 81 in *Robocop 2*, 106 in *Rambo III*, and 264 in *Die Hard II*.

It's time to say enough. While I am sick of record companies profiting from the violent rap they find a ready market for among white suburban and inner-city youths alike, I am just as sick of Rambos and Terminators and of video games like "Mortal Kombat" and "Night Trap" that portray decapitation, murder and violence as fun and entertainment.

The average preschool child watches over eight-and-one-half months of television before entering school. The lines between make believe and real life blur in rudderless children's lives, which lack enough caring adults who are transmitting positive values or helping these children interpret what they see. Is it any wonder that a teenage boy in Boston responded to the murder of an MIT student with: "What's the big deal? People die every day."

Second, let's stop the adult hypocrisy and double standards. Today, two out of every three black and one-fifth of all white babies are born to never-married mothers. And if it's wrong for 13-year-old inner-city girls to have babies without the benefit of marriage, it's wrong for rich celebrities and we ought to stop putting them on the cover of *People* magazine.

It is adults who have engaged in the epidemic abuse of children and of each other in our homes. It is adults who have taught children to kill and disrespect human life. It is adults who manufacture, market and profit from the guns that have turned many neighborhoods and schools into war zones. It is adults who have financed, produced, directed and starred in the movies, television shows and music that have made graphic violence ubiquitous in our culture.

It is adults who have borne children and then left millions of them behind without basic health care, quality child care and education or moral guidance. It is adults who have taught our children to look for meaning outside rather than inside themselves, teaching them in Dr. King's words "to judge success by the index of our salaries or the size of our automobiles, rather than by the quality of our service and relationship to humanity." And it is adults who have to stand up and be adults and accept our responsibility to parent and protect the young.

Step three is to mount a massive moral witness and mobilization against the violence of guns, poverty and child neglect in American life. The NRA, powerful firearms and ammunition manufacturers and sellers, the military-industrial complex, wealthy corporations and individuals who gained most from the unjust economic priorities of the past 12 years, and their political allies, will not untie the noose from our children's necks and nation's future unless a massive movement swells up from every nook and cranny of America. Parent by parent, youth by youth, doctor by doctor, religious congregation by congregation, school by school and neighborhood by neighborhood, we'll breathe life and security again into our democracy—if we are willing to risk our comfort and status today for our children's and our nation's tomorrow.

We must begin by taking guns out of the hands of children and those who

Jeff Guy and his cousin Kaira.

kill children. Whether you are a hunter, NRA member, gun owner, or not, I hope you will agree that child gun deaths must stop. Join in calling for a cease fire and for the responsible regulation of guns as the dangerous products they are. And I hope you will help spread the message that guns endanger rather than protect. A *New England Journal of Medicine* study found that a handgun in the home is 43 times more likely to be used to kill a family member or friend than for justifiable homicide. (Suicide victims are two and one-half times more likely to have guns at home. Over half of youth and child suicides involved guns.)

But crucial gun control is not enough to prevent violence and reestablish peace, love and mutual respect in our homes, neighborhoods and society. We must also address the breakdown of spiritual, family and community norms and just opportunity in America. Whether the focus is on random shootings or the drug epidemic or too early and out-of-wedlock childbearing, we are drawn back to the limited opportunities that lead too many children and adolescents to con clude that they have nothing to gain and little to lose. When our young lack a stake in our dominant values and norms, both we and they face a perilous road ahead.

Finally, determine that you will never become cynical or despondent about your capacity to help transform America and build nurturing families and caring communities.

Let me end with a story by Elizabeth Ballard about one school teacher, Jean Thompson, and one boy, Teddy Stollard. On the first day of school, Jean Thompson told her students, "Boys and girls, I love you all the same." Teachers sometimes lie. Little Teddy Stollard was a boy Jean Thompson did not like. He slouched in his chair, didn't pay attention, his mouth hung open in a stupor, his clothes were mussed, his hair unkempt and he smelled. He was an unattractive boy and Jean Thompson didn't like him.

Teachers have records, and Jean Thompson had Teddy's.

First grade: Teddy is a good boy. He shows promise in his work and attitude. But he has a poor home situation.

Second grade: Teddy is a good boy. He does what he is told. But he is too serious. His mother is terminally ill.

Third grade: Teddy is falling behind in his work; he needs help. His mother died this year. His father shows no interest.

Fourth grade: Teddy is in deep waters; he is in need of psychiatric help. He is totally withdrawn."

Christmas came, and the boys and girls brought their presents and piled them on her desk. They were all in brightly colored paper except for Teddy's. His was wrapped in brown paper and held together with scotch tape. And on it, scribbled in crayon, were the words, "For Miss Thompson, from Teddy." She tore open the brown paper and out fell a rhinestone bracelet with most of the stones missing and a bottle of cheap perfume that was almost empty. When the other boys and girls began to giggle she had enough sense to put some of the perfume on her wrist, put on the bracelet, hold her wrist up to the other children and say, "Doesn't it smell lovely? Isn't the bracelet pretty?" And taking their cue from the teacher, they all agreed.

At the end of the day, when all the children had left, Teddy lingered, came over to her desk and said, "Miss Thompson, all day long, you smelled just like my mother. And her bracelet, that's her bracelet, it looks real nice on you too. I'm really glad you like my presents." And when he left, she got down on her knees and buried her head in the chair and she begged God to forgive her.

The next day when the children came, she was a different teacher. She was a teacher with a heart. And she cared for all the children, but especially those who needed help. Especially Teddy. She tutored him and put herself out for him. By the end of that year, Teddy had caught up with a lot of the children and was even ahead of some.

Several years later, Jean Thompson got this note:

Dear Miss Thompson,
I'm graduating from high school. I wanted you to be the first to know. Love, Teddy.

Four years later she got another note:

Dear Miss Thompson,
I wanted you to be the first to know. The university has not been easy, but I liked it. Love, Teddy Stollard.

Four years later there was another note:

Dear Miss Thompson,
As of today, I am Theodore J. Stollard, MD. How about that? I wanted you to be the first to know. I'm going to be married in July...I want you to come and sit where my mother would have sat, because you're the only family I have. Dad died last year.

And she went and she sat where his mother should have sat because she deserved to be there. She had become a decent and loving human being.

There are millions of Teddy Stollards all over our nation; children we have forgotten, given up on, left behind. How many Teddys will never become doctors, lawyers, teachers, police officers or engineers because there was no Jean Thompson? No you? How many children will never learn enough to earn a living later because you and I did not reach out to them, speak up for them, vote, lobby and struggle for them?

How many times will you plead no time when a child seeks your attention? How many times will you refuse to serve the poor child because of the paperwork burden or write off the unruly and unresponsive child in your classroom, agency or neighborhood because you don't want to expend the energy or simply because you decide it isn't your job or responsibility?

Any one of us can become a Jean Thompson and every one of us must if we are to feel and heal our children's pain and nation's divisions. It takes just one person to change a child's life and to ensure that children like Teddy are not left behind, that they have a safe haven from the street, a voice at the end of the phone, or time with an attentive Big Sister, Brother or mentor.

Philip Leder '60 and his graduate son, Ben.

The most important step each of us can take to end the violence, poverty and child neglect is to change ourselves, our hearts, our personal priorities and our neglect of any of God's children, and to add our voice to others' in a new movement—one that is bigger than our individual efforts—to see that no child is left behind.

Do not be overwhelmed or give up because problems seem so hard or intractable. Abraham Lincoln kept going through depression and war and never gave up. And so the American union was preserved. Martin Luther King Jr. did not give up when he was scared and depressed and tired and didn't know what step to take next. And so the walls of racial segregation crumbled from his labors and that of countless unsung black and brown and white citizens. Elizabeth Glaser hasn't stopped fighting despite being affected by AIDS for 13 years and the loss of a child to AIDS. Her dogged and urgent persistence has contributed to greater attention to this killer disease. Sarah and Jim Brady refused to give up despite setback after setback and opposition from the powerful NRA, and the Brady Bill was signed into law in 1993.

Millions of children are still beating the odds every day and are staying in school and becoming law abiding citizens, despite the violence and poverty and drugs and family decay all around them. And so you and I can keep on keeping on until we change the odds for all American children by making the violence of guns, poverty, preventable disease and family neglect un-American.

God speed.

Marian Wright Edelman is founder and president of the Children's Defense Fund.

The Music of Medicine

by Matthew Davis

In the recital of life, we've come to a pause;
It's the end of a piece, and there'll soon be applause.
For a moment we'll rest, and then we'll resume
The performance of our lives and play the next tune.

(Fear not that you've attended the wrong graduation;
Medicine, not music, caused this congregation.
Yet the music of health will become apparent
As we talk about medicine and its rhythms inherent.)

There are those who would argue, "Why play on?
The face of medicine is changing—the thrill of it gone.
By the time you're my age, there'll be nothing left;
Of autonomy and reimbursements we'll be sadly bereft."

Bereft, I suppose too, of the many people who need us—
Who visit and call us and occasionally feed us?
No—if there are healers, there'll be those who seek them,
Just as those healers will try their best to treat them.

Note I said "healers," and not "doctors," per se;
That isn't an effort to be PC on this day,
But a comment on how we and patients relate:
Is it through healing or doctoring that a difference we make?

To heal, from its roots, is to make whole one's well-being.
To doctor is to teach—a very distinct style of seeing
The relationship, the duet, between patient and physician.
Is healing or teaching at the heart of our mission?

While you're chewing on that one, let me state and underscore
That both doctoring and healing possess at their very core
The common duet played out every time we see
The grandfather with angina or the well family of three.

Duets take many forms, some more equal than others;
We may hear paired voices, or one follows the other.
But they are definitely distinct from a solo performance
In which one voice sings while others lie dormant.

We've all heard the arias delivered before:
"Oh, doctor, my goodness, what should I do?
My palms are red, fingers white, my toes green and blue!
I did like you said, bought those tablets, took two,
But oh! did my stomach ache and before I knew it—I threw
Up all over and then noticed the grounds,
Coffee in color, with streaks of blood all around.
And did I mention to you, that my sister found
A new medicine from the Arctic—now how does that sound?"

Perhaps worse, physicians perform some confused solos as well:
"Mr. Doe, here's the 'script' for a newfangled pill—
We're not sure how it works, but take it, if you will,
Ten times a day with food, or more often still
If your symptoms worsen or you feel otherwise ill.
The side effects you'll feel are many and varied:
A little nausea, perhaps, but nothing more scary
Unless you develop dreaded Countway dysentery
That takes you out for one month and then fines you daily."

Dueling soloists of these types create little more than noise;
In the struggle to be heard, there's no ear for the other voice.
Chances are that patient soloists will continue to sing—
So it's up to us in each clinical concert to try to bring...

An ear for the music that each person produces.
And it's not just to words that this music reduces—
It's a crack in their voice, the slope of their shoulders,
A bruise 'round her eye, the way he grows older.

For every patient we hear, there's a tune unique:
The flow of each melody is what we can seek,
To which we'll respond as we, bit-by-bit, understand
How our tunes played with theirs can fit hand-in-hand.

Sound tough? Don't think you're fit for composing?
It's nothing supernatural that I stand here proposing,
But rather the sense of sharing nurtured in us from birth
That's thwarted by challenges to our very self-worth.

Co-moderators Rebecca Baron and Paul Allen.

Society masters Rosenblatt '73, Arky and Goodenough.

Yes, it's during those nights when your pager is raging,
New patients await you and slowly more irate, you
Become as you talk to and one-by-one walk through
Exam and exam and begin to wonder, Who am
I? A mere intern—the lowest of the low,
(Yeah, above med students, but what do they know?)
The patients become of their problems, a sum;
A number, a face. Individuality? No trace.

As physicians in the future, this devaluing may continue:
Fifteen minutes each visit?—President Bill, Just what is it
You expect me to do in fewer minutes than you
Spend with your doctor? I've trained a lot for
The right to spend more time to do more.
Yet I feel abandoned, alone, just like others, a clone
Of some bland EveryDoc who works 'round the clock
Just to see all the whoozits who've come in to visit—
But is it I who they've come to, or some health plan they've
clung to?

With this sense, this fear, that all compassion is lost,
That the System is broken, that it's all one big Cost,
It's natural to shut down our ears and not listen
And, in so doing, lose our clues as physicians.

While this self-preservation is natural enough,
For transforming our system, it's not the right stuff.
By not listening intently to the patients we serve
We lose their help, with which we can preserve

The duet of medicine as practiced in the past,
When doctors had more time and didn't talk quite as fast.
Physicians sat down with patients, not only heard, but
listened;
Patients felt they'd been heard out, and trusted physicians.

Although times may have changed, human ways have not.
A person in need needs an ear, a smile, a shot
Of reassurance, and how best to know what to offer?
Play the duet, not a solo; be a listener, not a talker.

To doctor...to heal...to play a duet—
For us as physicians, these actions will intersect
In rooms with our patients as we listen and reply,
Teaching, and healing—and learning on the fly
From patients as they play their songs of all kinds.
It's this that can lessen the weight of the grind.

So, in just a few days, with "MD" by your name,
When you're tired and hungry and your eyes are inflamed,
Remember why you're there and why your patient came:
To see you, and talk to you, and have you do the same.
There's music to be made, and not in solo form;
Duets lead to healing—from them ideas are born.
The essence of medicine is the patient and physician,
And in each one of you there's a medical musician.

Matthew Davis '94 is doing a pediatric residency at Children's Hospital in Boston.

More to Being a Doctor

by Vanessa Smith

THE ORIGINAL TITLE OF MY SPEECH was "Is There More to Being a Doctor than Liking Science and Liking People?" but it seemed a little wordy for the program as well as for the five minutes allotted to me. Ungainly as it is, however, it's a question I've been mulling over these past four years, as I've tried to pin down what kind of doctor I would like to be and would like for all of us to be.

I saw "liking science and liking people" as the theme of our orientation to Harvard Medical School four years ago. During orientation, the students in the class before us (many of whom are now actually in our class) showed us a videotape they had made to introduce us to life here. In one vignette a young man who had been accepted to Harvard on his third valiant try explained: "The first year I said I liked science and I was rejected. The second year I said I liked people and I was again rejected. But the third year I said I liked science and I liked people and here I am." Then I knew I was in the right place after all; the application essay I had spent three agonizing months on could basically be boiled down to that one line, although I used much bigger words to say the same thing.

I'd like to talk a little about these characteristics and others required to become a doctor today. "Liking people" is a quality to nourish, because it can be surprisingly elusive. In his book *Cancer Ward*, Solzhenitsyn describes the Rusanovs who, in their dedication to public service, fall into a trap that could possibly be hidden in our futures:

The Rusanovs loved the People, their great People. They served the People and were ready to give their lives for the People. But as the years went by they found themselves less and less able to tolerate actual human beings, those obstinate creatures who were always resistant, refusing to do what they were told and, besides, demanding something for themselves.

As this quotation points out, it is always easier to be faithful to an abstract ideal of humanitarianism than it is to, well, like people on a day-to-day basis. I hope that we retain some of the feeling of privilege and respect that we had when we conducted our first scary interview with a patient (but hopefully without the attendant feelings of panic that, God forbid, the patient would ask us something medical).

But, as our initial forays into the art of patient interviewing proved to us, we can't cure people just by liking them. If this were true our diplomas would be handed to us not by Deans Tosteson and Federman, but by Mr. Rogers and a big purple dinosaur. We must be relentless in our intellectual commitment.

For inspiration we can look around us to the incredible faculty who have served as our models and who make Harvard Medical School what it is. If we want to go back a bit further, we can look to the Maimonides prayer for physicians, which says: "Let me be moderate in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained sufficient knowledge, but vouchsafe to me the strength, the leisure and the ambition ever to extend my knowledge."

The third quality I hope we will continually develop is compassion. This is different from liking people, and different from sympathy, empathy or pity. It is the recognition of our privileged and precious role as physicians in one of the most fundamental of human experiences. It is the recognition that our tenure in the role of physician is limited. Last, it is the recognition that each patient we see on morning rounds is not just an index card of numbers, but a terrified individual, the focal point of family and friends who feel the same anxiety and sorrow we would feel in their places.

Heavy stuff. A career in medicine is one of the most profound and meaningful careers a person can choose. To keep us human, another important quality to nourish is a sense of humor. I first realized this before I came to Harvard when I saw my friend's grandmother, who unwittingly let me know how she viewed women in medicine. I told her that I had been accepted to medical school. She asked me which one and when I said

Another photo opportunity.

John Brooks talks with Castle Society master Marian Neutra.

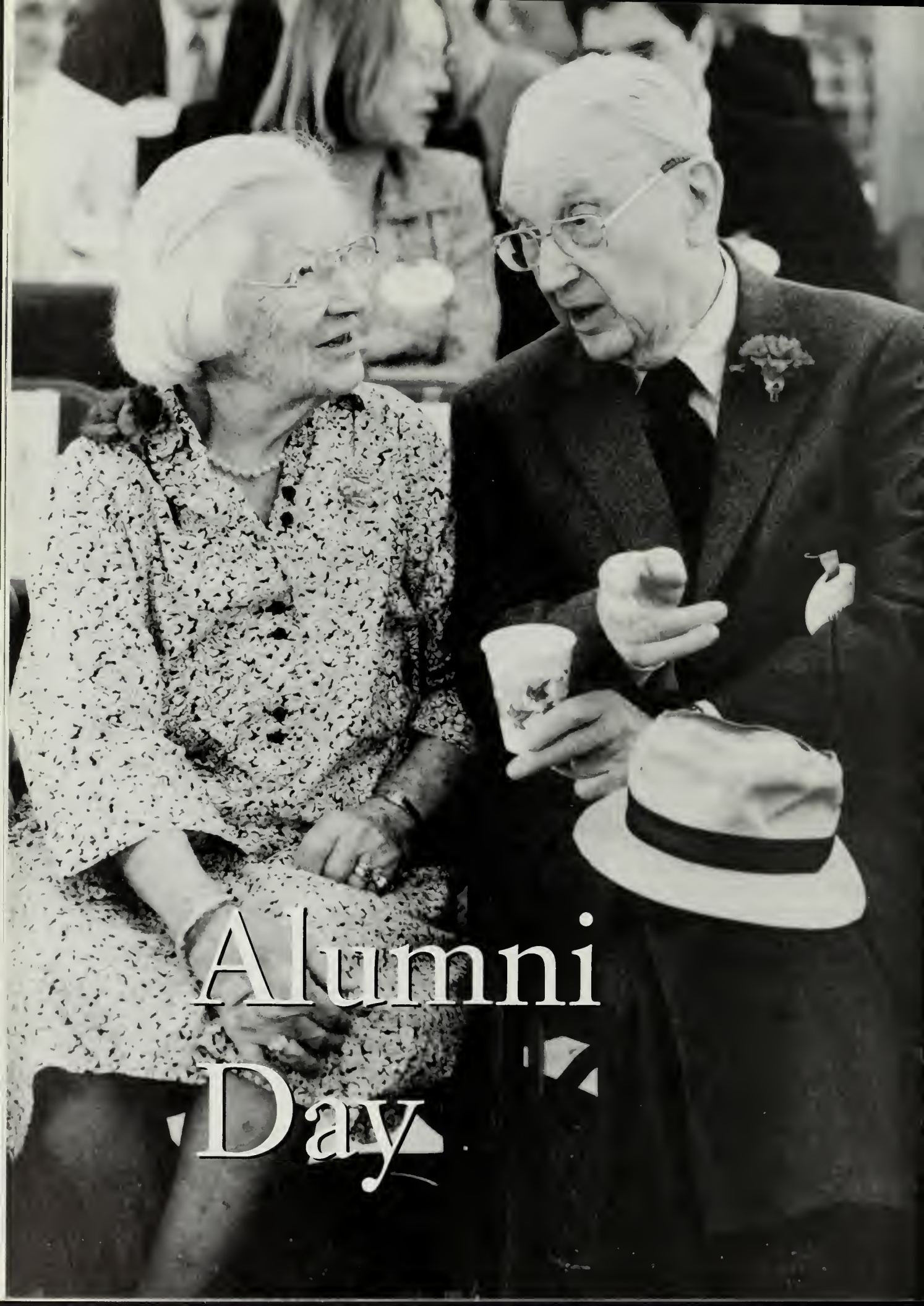
Harvard, her hands flew up to her face in astonishment.

"Harvard Medical School," she said with reverence. And then, overcome with the possibility, she added, "Maybe you'll marry a surgeon." Actually, Grammy gets the last laugh, because I am going to marry a surgeon, but also I'm going to be one.

A recent newspaper survey showed that although the majority of people said that they wanted their own doctor to be a friendly kind of physician who would know them and their families intimately (that is, someone who likes people), if they ever got really sick they wanted to be treated at the Mayo Clinic (by someone who likes science). These two conditions are difficult to reconcile in a national health program but not impossible to combine in one doctor. I have high hopes that our class will be able to transcend the public's expectations and incorporate these characteristics in our practice of medicine.

Vanessa Smith '94 will begin a residency in otolaryngology at Cleveland Clinic.

Edward Hundert '84, dean for student affairs, surrounded by some of his charges; Rebecca Baron, Carey Farquhar, Ed Chan, Eric Chang and Matthew Davis.



Alumni Day

THE SIGHT OF FRIENDS REUNITING was as heartwarming as the day's sunshine. Smiles, handshakes, hearty laughs and pats on the back were the day's decorum; lapels and lacy collars sporting dark red carnations were the day's style.

Daniel Federman '53, who added the role of director of alumni relations to his decanal duties one year ago, conducted the annual business meeting. Looking out over the large audience, he remarked that there are more living alumni now than ever before, and said his office welcomed letters and advice: "If you make a suggestion, I can assure you we'll put it to very good use."

Merrill Greene '24

He cited the success of the networking program established last year, which links students planning to visit residency programs around the country with alumni who live nearby; and praised the program in minority recruitment: "HMS has now graduated more minority physicians than any other nonminority medical school in the United States."

Council president Robert Glaser '43B took to the podium and garnered unanimous agreement to skip reading the minutes because secretary Nancy Rigotti '78 was on jury duty. He announced the new appointments to the council: Suzanne Fletcher '66, president-elect 2; Arthur Kravitz '54, who will succeed Mitchell Rabkin '55 as treasurer; and new councilors Dana Leifer '85, Sharon Murphy '69 and John Stanbury '39. And, calling the *Bulletin* "a magnificent publication—the envy of other organizations who produce similar things," he thanked Gordon Scannell '40, who after a 14-year tenure as its editor, is retiring.

Doris Bennett '49, the late chairman of the Alumni Fund—who Glaser called "a wonderful colleague and wonderfully devoted person to the school"—was remembered in a moment of silence. Federman stood in for her to report that almost 50 percent of alumni participated in the annual fund drive, resulting in $1,100,000 for unrestricted use. An 80 percent participation rate in the Class of '44 made class agent Chester d'Autremont's job of presenting a class gift of $115,000 "rather pleasant"; and George Thibault '69, who swore his class wasn't competing, presented his class's 25th-year reunion gift of $116,000—the entire amount allocated for student aid. (Final totals are $125,040 from the Class of '69; and $118,482 from the Class of '44.)

With a small tap, Glaser turned the gavel over to his successor, John Stoeckle '47, "the epitome of what I think we like all of our graduates to be." And the business meeting was adjourned.

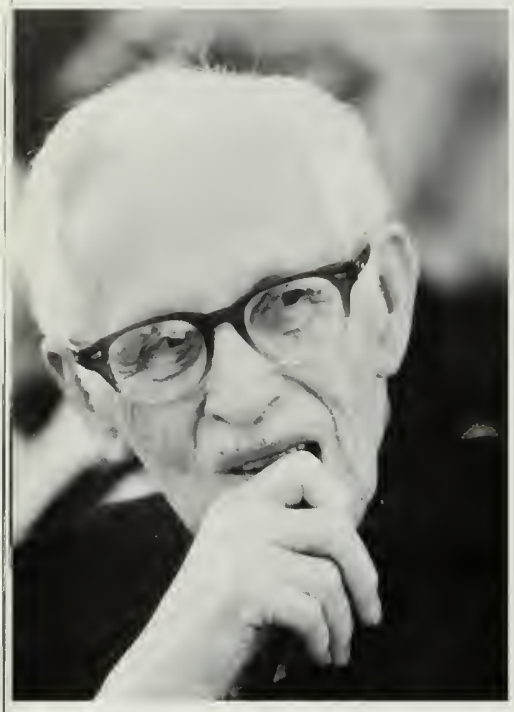
"This morning, you are the students," said Federman to open the symposium entitled "Ethical Dilemmas of the 1990s." Wanting to reflect the New Pathway problem-solving learning method—"which is meant to keep everyone thinking about what's new, what could be new, and about how medicine could be doing its job better"—Federman encouraged the alumni audience to be active participants, to think of the symposium as a forum for ideas, not as a passive lecture. Alumni responded with enthusiasm when it was their turn, quickly queuing behind the microphones set up in the aisles.

John Stoeckle '47 spoke of the "marriage" to medicine, which despite the love left in the relationship, is currently in need of counseling. Of the many pressures facing the practice of medicine today, he highlighted a few: the corporate organization of practice; capitation payments; professional equity among the specialties; and duties to patients at the end of life. He acknowledged that it is hard to know what is the right thing to do, but urged that care be delivered with "participation of our professional values...no matter what."

Margaret Hamburg '83, commissioner of the New York City Department of Health, followed with a

Bob Taylor '44, Hank Bahnson '44 and others applaud Greene's wit.

Bebe Hartman talks with Benjamin White '34.



Robert A. Clark '34

discussion of one of the overriding dilemmas in the discourse on health care reform: unlimited hope and limited resources. Because of the research efforts of HMS and other institutions, the United States has some of the most sophisticated medicine anywhere, but the ability to both allocate and pay for it is daunting, she said. "In too many ways, the U.S. health care system is a study in contradictions—a paradox of want among excess."

Hamburg urged an end to the sidestepping of such issues as the rationing of care, the variability of care according to race and income, expensive and unnecessary testing, and the crucial importance of public health measures: "Historically, it is important to note that despite the dazzling array of advances in biomedical technology and treatment strategies, it is public health measures that have played the greatest role in reducing disease."

Then it was the audience's turn to sound off. Someone asked what could be done to speed up the health care reform bill and get the kind of changes one would like to see. Advocacy for "what we believe should be the central components" of reform is critical, responded Hamburg.

Another kind of advocacy—on behalf of patients—was a recurring theme in questions and answers. Alan Freedman '59 pointed out that doctors are given a sacred trust to care for patients, but that managed care puts trust in the bottom line. How do we preserve our values? To be the patient's advocate is indeed sacrosanct, said Stoeckle, and takes precedence over institutional guidelines, which while necessary, should not dictate care.

George Richardson '46 elicited cheers from the audience after he eloquently made a case for an inspired reaction to all this talk about care of the patient. "Why should health care stop with only 13 percent of the GNP?...Somehow the expensive mobilization of WWII led to prosperity. Wouldn't it be wonderful if we had a mobilization for health and if our doctors and medical institution had the brass to say, 'Look, boys, we know the priorities. We are not going to sit in offices using niggling cost-effective care. We are going to help the suffering. We will sit with patients and find out what is troubling them. The buck will stop at this office'."

Another alumnus pointed out that patients have to take more responsibility for their own health or we won't achieve savings. And Jay Jackman '64 made the point that health care reform issues need informed and involved physicians, and he's not so sure the profession is prepared. "Public health can make enormous differences, but the direction we're going in is to be concerned about profit, and profit comes from the practice of medicine, not the prevention."

Gilad Gordon '83 commented that as someone with economics training, he has been struck with the naiveté of other economists who talk about rationing, say by limiting x-rays to five per week. "What do I do with the sixth that is necessary?" Instead, he would like to see attention paid to eliminating duplication of technological efforts, for example, eliminating multiple transplant centers in a city for which one would satisfy demand.

A brief encounter with HMS's oldest living alumnus sparked an unexpected chuckle. Merrill Greene '24, a general practitioner in Maine for many years and now medical examiner in Lewiston, has had buildings, a school gym and a ballfield named for him in appreciation of all he has given his community. "Our academic and scientific achievements are often better known, but here is a man who has lived the values and expressed very salient purposes of Harvard Medical School," said Federman in his introduction.

The 94-year-old alumnus, the sole attendant of the 70th reunion, stood before the microphone and faced the audience. In what initially purported to be a short, somber moment quickly gave way to an impromptu speech filled with a teasing wit that had the audience laughing unabashedly and looking at each other with surprised delight.

"Just recently I was notified that I was elected, and not only elected, but elected unanimously as a class agent for my class," said Greene. "I admit that I did a little campaigning."

With a wink to the audience, he continued: "I was a little mortified to find in the program that my class isn't even mentioned, but I'm going to get the class together and we're going to have a protest." After delivering his opinion of the health care reform packages being presented by Hillary and "Billary," he talked about his grandmother who taught him to respect his elders: "So I'd like to tell you people that I have respect for you."

And with a few more anecdotes, he was delicately led away from the mike—but not before getting the last laugh: "It is by unanimous vote that I leave," he quipped, and the audience howled. The only suitable response to that was a quick rush into Building A for another cup of coffee and a pastry. After more mingling, it was time for

the second part of the program.

Mitchell Rabkin '55, president and CEO of Beth Israel Hospital, discussed how the factors of professional excellence, process efficiency and personal expectations must all be balanced in the delivery of quality health care, particularly in a large academic hospital—a challenge made much more immediate by the changing economic environment. "Some would argue that personal and professional standards of the physician remain closely integrated, but institutional standards are increasingly vulnerable under economic pressures." He urged physicians not to be drawn into the vortex where "ethics is ethics, but business is business."

"What's in an oath?" asked Nathaniel Hupert '94, who the day before had joined his graduating class in swearing to a newly written oath to the practice of medicine. His class had rejected the several options for a commencement day oath, including the ones attributed to Hippocrates and Maimonides, and the oath written by the Class of 1991. The students chose instead to write an oath they believed more completely described the values, both personal and social, they felt were required of someone about to become a physician. "We took very seriously the task of creating this oath, because we felt that in these times of heightened scrutiny of both the science and the practice of medicine, we should not underestimate the importance of a public display of the ethical commitments of its newest practitioners."

David Rush '59 started the next question-and-answer session, pointing out the importance of violence as both a personal and local concern—one that is now the central issue of Physicians for Social Responsibility. He then asked Hupert if the class had thought of putting something in the oath about the participation of the medical profession in the death penalty. Hupert answered that the class decided not to offer specific proscriptions on abortion or the death penalty, for example, but covered general concepts of justice.

Applause erupted when Al Gundersen '49 closed his comments about their nonproductivity-based group practice model with: "Some of American medicine is urban and some is rural. For God's sake, don't destroy some of the good elements that exist today."

Robert Lawrence '64 then offered his thoughts. Referring to the oath, which mentions responsibility to one's community, he said that he felt such responsibility, but that we need to keep the big picture in mind when we define community. "It would be nice to invest more in the health care sector, but our commitment to the social sector—education, security—is declining."

And the last comment of the day came with a plea from Hal Reuter '59, who said he was concerned that as government became involved, a lot of money would be used for bureaucracy. "I urge all of us to get involved with controlling our own futures."

Dean Daniel Tosteson '49, who was also celebrating his 45th reunion, reported on new developments at the school. There were 42 new full professors named this year, bringing the total to 412 out of approximately 13,000 faculty appointments at the school (including junior faculty, instructors and trainees). The dean updated alumni on the Harvard Institutes of Medicine (see story page 11), the search for a new dean for faculty development, who will be responsible for coordinating efforts to further diversify the faculty, and on efforts to refocus the curriculum with more of a primary care component.

The dean also cited the remarkable generosity of Leonard and Isabelle Goldenson, whose planned gift of $60 million is the largest ever received in the school's history (see story page 8). That led to more fundraising news. The university's $2.1 billion campaign was kicked off in early May, and the medical school's part is to raise $220 million, of which $98 is already in the nucleus fund.

Keying off Margaret Hamburg's title, the dean said, "We do have unlimited hopes but not unlimited resources." He closed the morning's session with this inspiration: "Discoveries of medical science not only encourage old hopes but create new hopes; it is a continuing struggle between fulfilling those hopes and trying to contain the costs. I believe it is our job to fulfill the hopes."

Virginia Warthin, Frederick Hartman '34 and John Dziob '34, who brought his son Michael with him to Alumni Day, listen to the speakers.

Pressures on Professionalism

by John D. Stoeckle

IN THIS OUTDOOR TUTORIAL WE ARE all again at HMS, not only to reminisce as is the custom, but to get informed and maybe to problem solve and reflect in the spirit of the New Pathway. Speaking as but one of the many ex-students here, I think our profession needs help of a certain kind. It's our professional distress—pressures on our professionalism—that is my theme: pressures on our work, identity, and on our values. Our history about this distress is brief; here's what has happened.

We came to HMS to become doctors. It was here we got our medical education and got married, in part, to medicine. The marriage was and is a great lifelong contract and attachment to serving patients and the public in their search for the healthy body and a long life. But today our connections in this marriage-to-medicine and its mission seem troubled. While our contract and attachment to serving patients and the public—our professionalism—may not be ready for separation or divorce, it is certainly under strain from inside and outside.

We can call our professionalism, in plain language, trying to "do the right thing." Others would call this "medical ethics," a discipline that can explain the principles of our "right actions" in care and treatment, which are not merely technical but psychological, social and ethical. Putting definitions aside, with so many pressures on the professional values that we learned at HMS, today we need help among ourselves, in our organizations, and with our patients to "do the right thing."

Everyone here knows these pressures. They come out of the changing reforms of financing, organizing and managing health care. Of the many pressures on our professionalism, only four are for your reflection: the corporate organization of practice, the capitation payment of the doctor, professional equity among ourselves, and our duties to patients at the end of life. These four pressures involve purpose and power, money, loyalty and moral behavior; they come out of the organization of care, the payment of care, our doctor/doctor relationships and public opinion.

Pressure 1, Problem 1: Purpose and Power

Corporate organization of care is here and getting bigger every day. Hospitals and group practices of all kinds are getting bigger by joining together, even as some hospitals and practices are closing or downsizing. Call them partnerships, affiliations, amalgamations or conglomerates, they are corporate, industrial expansions and buyouts, just like the airlines and banking industries have gone through. This corporate reorganization of practice is a familiar topic everywhere.

One result is that the MD is becoming an employee (as many of us already are) in what are now business organizations. The service mission of these corporations (as studies of our hospitals have shown) is to be a profitable enterprise, no longer a charitable therapeutic institution for all the community. Some 60 percent of the 650,000 MDs in our profession are said to be employees, salaried in all or some of their work. With this growing corporate organization of clinical work come questions that are being debated, some often ignored.

- In the governance and mission of the corporation, are we to be employees without a professional say in the nature of service provided to patients and the public, while the business goes "where the money is"?
- In the corporate drive for standardized, technical efficiency, is professionalism in providing personal care to patients—attention to the social, psychological and ethical needs of the patient—really needed, or are only our technical skills and procedures?

Pressure 2, Problem 2: Loyalty

Capitation payment of the doctor is here and growing too. It used to be said the doctor owned the patient. No more. Insurers own the patient. Not even the patient owns him- or herself in choices for medical help, as many learn on reading the fine print of their insurance policies. With insurers making capitation payment to primary care practitioners, the doctor's function is now, for business purposes, as "gate keeper."

As gatekeeper, the MD is expected to reduce medical consumption. The

doctor is now a kind of health care "cop" for insurers, expected to discourage doctor visits, testing (whether diagnostic or therapeutic), and specialist referrals, thus saving insurers money and possibly making more him- or herself.

- Should the MD serve the patient or bend to serve the managed care insurers and business?
- Would the MD serve the patient better with more health promotion, some disease prevention, more disability rehabilitation, better and more care

of chronic illness (that all of us will sometime get), and share that care with our specialist colleagues—all of which might cost more, not less?

Pressure 3, Problem 3: Money

Professional equity among practitioners. In our profession a wide difference in rewards has developed with specialization. Specialization has contributed new knowledge, skills and procedures for the improvement of patient care. No question. It has also gained more income for its practitioners. No question either. But talk about this monetary differential is a taboo theme among ourselves. (Though Harvard's emeritus president, Derek Bok, recently broke the taboo with a book, *Pay for Talent*, that includes medicine, of course.)

Regardless, as colleagues, we are not, as Hippocrates stated, all "brothers and sisters." We are stratified in our professional family and in the shared care of patients by a wide differential of rewards for services. (And we now pay the executives of our service institutions salaries like the CEOs of industry.)

- As specialists and generalists working together in shared care of patients, should there be more equity among us in fees and procedures—in the pay for providing care and treatment?
- Would more equity provide more professional exchange in patient care, making better shared care, rather than rationing specialist services because of cost?

Pressure 4, Problem 4: Moral Behavior

Duties at the end of life. In the last two decades, all of us have learned to ask for informed consent, discuss Do Not Resuscitate (DNR), begin shared decision-making with patients, and listen to patients about their requests for "living wills," or advise them how to fill out an "advanced care directive." We have improved the communication of information about illness and treatment by involving patients in clinical decisions and fulfilling our ethical obligations to them.

- Are we then to go still further in a more radical direction? Namely, are we to follow public opinion reflected in surveys that show that 70 to 80 percent of the public would approve of assisted suicide, and where some 30 percent of our profession is reported to be ready?
- Or are we to resist and temper such demands on our ethos of care by exploring with the patient what underlies such requests—their real concerns in dying, of loneliness and suffering—while we continue our efforts to relieve that suffering?

Enough Pressures, Enough Problems

With these pressures on our professionalism (and there are many more), what is the right thing to do? Answers, of course, vary. Our directions, I think, should be for shared not competitive care, namely care with participation of our professional values. By participation with our professional values no matter what, care will certainly be better in every context:

- better when, even as employees, we have a say and share in the governance and organization of the corporation, a say that promotes all dimensions of care and treatment for the needs of the patient and the public;
- better in the personal care of individual patients when we continue as their personal advocates in a shared care-taking role (even as we separately set public standards and practice guidelines for care and treatment);
- better as we press for more professional equity in our common work of care among ourselves, whether generalists or specialists;
- and better in our continuing communication and shared decision-making with patients from the beginning to the end of life.

I hope you will help us with this professional distress, of learning to "do the right thing" for the care of patients in the organizations in which we work, together with our patients, and among ourselves.

John D. Stoeckle '47 is HMS professor of medicine emeritus, a member of the editorial board of the Harvard Medical Alumni Bulletin, *and the new president of the Alumni Council.*

An Old Room Made New

Many years ago, $25 bought an admission ticket to a lecture on materia medica by Jacob Bigelow. For the same price, an adventurous young man—and these coveted tickets were sold only to men—could buy a much more elaborately scripted ticket to attend a lecture on theory and practice of physic by none other than George C. Shattuck. It was 1788, six years after a school of medicine for Harvard College was proposed and accepted by the fellows and president.

Clem Hiebert '51 talks with Gordon Scannell '40, who is retiring from the *Bulletin* after 14 years.

Over a century later, several similarly stalwart albeit slightly older alumni, which this time included even a few women, wore white carnations, noshed on strawberries and asparagus and sipped champagne while they perused an exhibit of several remnants—photographs, personal letters and original documents—from those early days of Harvard Medical School. The exhibit, organized by Nora Nercessian, executive director of the Alumni Association, and Daniel Federman '53, director of alumni relations, hangs in the Alumni Council Room and on the walls outside on the third floor of Building A; it is the pièce de rèsistance of an old room with a new mission.

The atrium was orginally given to the Alumni Association following the renovation of Building A as a place for lounging. But, said Federman, who is also dean for medical education, "HMS alumni don't lounge." So, the area was given new meaning during a dedication ceremony on June 7. "Alumni can now put the room to much more active use," said Federman.

Portraits of alumni who served well and long—editors of the *Bulletin*, directors of the association and chairs of the Alumni Fund—hang along one wall inside the council room. In a particularly poignant moment, Warren Bennett '47, husband of the late Doris Bennett '49, who served as chair of the Alumni Fund and died only a few weeks before alumni week, added her picture to the wall.

While Federman told the history of the school, those congregated turned towards the panels of pictures he indicated: the now infamous photo of the first class of women admitted to HMS; a handwritten letter from a Mrs. M.C. Buchan, who served tea on the Quadrangle during the dedication ceremony of the campus in 1906; and pictures of the construction that resulted in the white marble buildings that now house the school.

"We're all delighted with this room and what's happened in this gallery," said Robert Glaser '43B, outgoing president of the council. "It's nice to have a room that brings back memories."

The dedication also served as a time to thank and acknowledge J. Gordon Scannell '40, who after 14 years of editing the *Bulletin* is retiring. He was presented with a magnificent set of all the issues of the magazine he had edited, luxuriously bound in leather with marbled paper covers.

After the program, alumni mingled while examining the photos and documents on display.

"I love it," said Eleanor Shore, '55, dean for faculty affairs. "This should have been done years ago." Looking around she recalled the area's original use as home of the Warren Anatomical Museum.

A picture of the museum in its heyday, when it filled the top three floors of Building A with 11,000 anatomical specimens, surgical instruments and other artifacts, is also on display. Beneath it is a 1922 photo of a group of visitors from Massachusetts Mental Hospital standing around the Phinias Gage exhibit.

"It's wonderful to have the history on the walls," said Shore.

Terri L. Rutter

Warren Bennett '47 and Daniel Federman '53 look at a photo of the first class of HMS women, which included Bennett's late wife, Doris Rubin Bennett '49.

Unlimited Hope/ Limited Resources

by Margaret A. Hamburg

THIS IS A CRITICAL TIME FOR MEDICINE and health—both because of the many daunting health problems before us, as well as the opportunities to truly make a difference. Yet it is also a time when economic pressures and competing priorities demand that difficult decisions be made. Looking to the future, we must recognize and grapple with the dilemma of unlimited hope and limited resources.

We must examine such complex questions as what care should be given, by whom, for whom and under what conditions. We must look carefully to see whether the care we offer is appropriate, necessary and delivered in the most cost-effective way possible. And we must set priorities—both in terms of activities, commitments and values within our health care system and more broadly.

On the one hand, what is the relative investment that we should be making in the different elements that contribute to our health care system, including basic research, applied research, public health and, of course, direct care? On the other hand, how should our investment in health care compare to other important societal goals, such as housing, education, employment or national security? And to what extent can and do investments in these collateral social problems actually result in significant gains in health and/or containment of health care costs? Obviously there are not easy answers to these questions, but the issues must be raised.

As we sit in the courtyard of this great medical school, it is hard not to recognize and take pride in the truly remarkable advances that have had such powerful implications for our understanding of health and disease. Especially in recent decades, biomedical research has led to a virtual explosion of new knowledge, with practical implications for both the prevention and treatment of disease.

Academic medical centers, such as this one, have been at the forefront of these research efforts and have played a crucial role in the practice of medicine, offering state-of-the-art diagnosis, treatment and care, as well as quality training for young medical professionals. Without question, thanks to the efforts of this institution and many others, the United States boasts some of the most sophisticated medicine found anywhere in the world.

Yet we must also recognize the irony of our situation. Side-by-side with our country's first-class medical institutions, there exist urgent and widespread health needs: individuals who lack access to even the most basic care; communities whose health status indicators rival those found in many countries of the developing world.

In too many ways, the U.S. health care system is a study in contradictions—a paradox of want among excess. As a nation, we spend an enormous amount of money on health

care—as much as 13 percent of our gross national product—and the costs of health care are growing faster than the total economy. Yet despite this enormous outlay, a staggering amount of need remains unmet.

Nationwide, as you are well aware, some 37 million Americans currently lack health insurance; millions more lack access to routine primary and preventive care—the kind of care that is most likely to meaningfully reduce the burden of unnecessary illness and premature death, as well as to diminish the many disparities in health that are linked to poverty and inadequate access to care.

As we enter the era of health care

reform, it is abundantly clear that current patterns of health care spending cannot be sustained. Furthermore, there appears to be a new consensus that as a society we can no longer tolerate the inequities manifested in our present system. We must find better ways to utilize our health care dollars and to share the wealth of modern medicine.

How can we effectively and fairly achieve these goals? What is the most reasonable and equitable means to allocate resources and refashion the delivery of care? These kinds of questions, of course, raise the issue of rationing. For many reasons, there has been great reluctance to explicitly talk about rationing in our health care system, viewing it as an extreme measure to be undertaken only as a last resort. But the reality is that rationing is already happening—though generally not as a deliberate or specific plan.

Raquel Cohen '49 looks at pictures with Ruth and Arnold Segel '32.

Currently in this country the most obvious examples of how we ration care are based on ability to pay, insurance rules and the adequacy of health insurance coverage. In general, those who can afford it, get better care.

Other more subtle factors also influence and limit what health services people receive. For example, it appears that the quality of care and availability of services varies tremendously by race. A number of recent studies suggest that for similar conditions requiring similar medical procedures or interventions, blacks receive less medical treatment and worse care, regardless of ability to pay or socioeconomic status. Unfortunately, this disparity in care has been found across many hospital and clinical settings—urban and rural, public and private—and has been demonstrated to negatively influence the treatment and prognosis of such serious conditions as AIDS, heart disease and cancer.

Distinct regional differences in medical care also exist. For example, a study of rates of hysterectomy in Maine revealed that in one region, there was a 20 percent likelihood that by age 70 a woman would undergo an hysterectomy, while the rate was as high as 70 percent elsewhere in the state. It is hard to imagine that in this one state there would be such striking differences in medical need. Yet clearly there are regional differences in physician practice and what one might call the culture of care. In these instances, geography may be destiny when it comes to the level or type of health care someone receives.

There are other examples, as well, of how resources may be allocated in ways that do not make good sense, either medically or morally. In a world of limited resources and compelling needs, we must limit costs and allocate resources in a more desirable way. We do not necessarily have to talk about rationing if it makes people queasy and ill at ease, but we must address head-on the need to develop a rational, workable and defensible approach to the allocation of limited resources, one with explicit criteria, understood and accepted by health care consumers, medical professionals and society at large.

In many ways, the current attention focused on health care reform gives us the opportunity to seriously pursue some of the issues that should govern health care spending in the future.

First, we must find ways to reduce costs. One important way to do this is to set restrictions on who receives care, based on such factors as medical need, life expectancy or prospects for recovery. It will not be easy to set criteria or implement them, yet they must be grappled with.

Another approach is to set restrictions on which services are provided, limiting wasteful or marginally effective care. There is increasing evidence that a distressingly large amount of health dollars are being spent on inappropriate or unnecessary diagnostic tests, procedures, hospital stays, physician visits, medications, etc.

Numerous studies have attempted to measure rates of unnecessary or inappropriate care. While these studies vary considerably in quality and content, some striking findings do stand out. For example, in a study of carotid endarterectomy, some 32 percent of procedures were deemed inappropriate and another 32 percent equivocal; a study of coronary angiograms suggested that 17 percent performed were inappropriate and 9 percent equivocal; a study of upper GI endoscopy suggested that 17 percent were inappropriate and 11 percent equivocal; and in two different studies of cardiac pacemakers, the investigators found that

they were overused from 20 to 75 percent of the time.

Multiple factors drive this phenomenon, including an over-reliance on technology, malpractice concerns, the "can do" ethic of American medicine, and an incentive system that makes it possible for neither the provider nor the consumer to feel the financial impact of an intervention ("The insurance covers it, so why not...").

Forces such as these are perpetuated and reinforced over time. Modifying the current state of affairs will require substantial changes in how we, the medical profession, do business and in the expectations of consumers and society. Nonetheless, there are significant steps that can be taken, and many are already under way.

For example, I think we can reasonably expect an increasing emphasis on medical effectiveness research and the development and implementation of medical practice guidelines. Correspondingly, there will be more stringent assessment of new technologies, limits on their use, and probably ongoing restrictions on the distribution of facilities, equipment and supplies through regional planning strategies.

Additional steps to reduce costs can be found in other arenas as well, such as streamlining administrative costs, limiting excessive provider charges, and reforming the medical malpractice system. While it is difficult to determine the actual savings achieved through these various strategies, it is clear they would be substantial. Needless to say, these approaches—either alone or together—will not solve the problem, but they offer meaningful opportunities to reallocate resources for more effective health needs.

Toward that end, we must take a hard look at our priorities for health care spending. One reason for the apparent imbalance between the heavy investment being made by our country in health care costs and the tangible returns is, I believe, our over-reliance on the traditional health care system. As a profession and as a society, we have invested heavily in the development of acute care medicine to treat individual disease conditions once they are established. Certainly this has led to important breakthroughs that have improved health and saved lives. Certain aspects of this approach have also contributed to escalating health care costs. And perhaps most significantly, it has led to a tendency to overlook and underinvest in other strategies of demonstrated value for improving health.

As commissioner of the largest local health department in the country, I have to take advantage of this opportunity to say just a few words about the importance of public health. In an era of limited resources, we can no longer afford to think about health care exclusively in terms of patient-specific clinical care and medical services.

While health care services—and how we deliver them—certainly have a significant influence on health, most of what is important for health occurs outside of the purview of patient care and the health care delivery system.

Historically, it is important to note that despite the dazzling array of advances in biomedical technology and treatment strategies, it is public health measures that have played the greatest role in reducing disease, increasing longevity and improving the quality of life and health status of our citizens. Throughout the past century, the most significant gains in health have come from public health programs ranging from sanitary inspection and protection of the food and water supply, to control of communicable disease through immunization, diagnosis and treatment, contact-tracing and, when necessary, isolation.

Today, important public health activities include surveillance and con-

Gloria Singleton-Easton '74 joins dental school graduate Dolores Franklin, Class of '74 at the annual Coleus Society reception. Due to low turnout the past couple years, this year's reception was to be the last for the society dedicated to the particular concerns of minority HMS alumni. But the enthusiastic schmoozing that filled the Minot Room in Countway Library ensured its recovery, said Daniel Federman '53, dean for medical education.

Alvin Poussaint, faculty associate dean for student affairs, remarked that notable about this year's reception was the number of HMS students, particularly those in their first and second years, who attended. These students are a reflection of a very different environment for African Americans than when Cyril Jones '44 attended HMS. Jones, who was back for his 45th reunion and also attended the reception, was one of only two blacks in his class. In fact, HMS—which has graduated more minority medical students than any nonminority college in the country—received an award this year for its efforts (see page 9).

trol of communicable and other diseases, protection from environmental hazards, health education and disease prevention programs, patient-specific disease control interventions, and clinical services for indigent and underserved populations. Many of these activities do not occur in a doctor's office or in a clinical setting, yet they are unarguably vital to the health and well-being of our citizens.

Disease surveillance, for example, serves both as a sentinel alerting us to new or re-emergent threats, and as a research tool enabling us to quickly devise interventions that stem the spread of disease. Data collection and surveillance activity have allowed us to identify and respond to so many infectious disease problems—from AIDS to multi-drug resistant TB to Legionnaires' disease or the recently recognized hantavirus outbreak—as well as to better understand the relationship of certain risk factors to certain chronic disease conditions, such as the link between smoking and heart disease or high fat diets and cancer.

In addition, the formidable epidemiological tools of public health can be employed to gain deeper understanding of, and devise interventions for, areas of public concern—violence and injury prevention, for example—that traditionally have not been considered health issues.

Through health education and promotion efforts, public health also has achieved success in changing behavioral patterns involving such health risk factors as tobacco and alcohol use, diet and exercise. The benefits of such change are difficult to calculate precisely, but they are obviously immense, whether measured in lives saved, decreased human suffering or economic losses averted. For example, since 1970 we have witnessed close to a 50 percent decline in the number of stroke-related deaths, largely attributable to these public health—rather than purely clinical—interventions.

Indeed, public health interventions reflect public health's role as "physician to the entire population." Not only are public health activities essential for attaining our national and local objectives but, as the proverbial ounce of prevention, they collectively represent an extremely cost-effective element of national and local health strategies.

It is thus somewhat surprising that while our nation is spending almost a trillion dollars a year on health, less than one percent of it goes to fund public health programs. If we truly seek to maximize opportunities to improve health in an era of fiscal constraint, then surely we must make a renewed commitment to prevention and public health.

These are just some of the complex problems for which there are no easy answers. Certainly, the debate over national health care reform has helped make explicit some of the dilemmas before us. We must seize this opportunity to put in place a just and universal health system. But to do so, we must slow the growth of our health care spending without stifling innovation or denying people necessary care. In this era of limited resources, we must reallocate resources so that they are used appropriately and truly to improve health.

Margaret A. Hamburg '83 *is commissioner of the New York City Department of Health.*

George Thibault '69 talks with Alan J. Friedman '59.

That Was Then, This Is Now

One theme ran through all the presentations at the Class of 1969's symposium; medicine has changed dramatically in the last 25 years. The 25th-year reunion symposium began with three presentations on major advances in science and technology.

The first speaker was Curt Freed, a professor of clinical pharmacology at the University of Colorado, who described his work on Parkinson's disease. Freed helped develop a method in which dopamine-producing fetal cells are injected into the brain in order to counteract some degenerative effects of Parkinson's disease. Freed's group showed the success of this method in at least temporarily ameliorating the clinical effects of Parkinson's disease in a trial involving 10 patients.

Michael Harrison, professor of surgery and pediatrics at the University of California at San Francisco, has pioneered an equally fantastic procedure. He described his method of taking a fetus from the uterus, repairing an anatomical defect (such as a herniated diaphragm), and returning the fetus to the womb for later delivery.

Michael Gimbrone, Elsie T. Friedman Professor of Pathology at HMS, has discovered that by observing changes in the molecules on the surface of the endothelium that lines blood vessels, we may be able to predict the development of arteriosclerosis, a key also to a strategy for preventing stroke.

The second panel of the day was devoted to changes in the climate of medical practice. While technological advances have been great, economic pressures have cast a pall over what were previously limitless opportunities.

The 1960s was a time when research opportunities, in particular, seemed without bounds, as Robert J. Mayer, HMS professor of medicine, pointed out in his speech entitled, "Specialists Versus Generalists: The Pendulum Swings." "There was a seemingly unlimited amount of third-party reimbursement and research funding, and subspecialists were viewed as having enhanced prestige and greater income..."

But public opinion has changed just as there continues to be a steady decline in primary care physicians. Mayer believes that physicians can wear both hats at once. "I take care of many patients whose cancers have either been cured or placed into long-term remission, for whom I was their general internist."

At the beginning of his presentation, "Perspectives from a Primary Care Practice," Thomas P. Hyde of Williamstown Medical Associates focused on how things have not changed the past decades: "One is that the process of making medical care decisions is a mutual and cooperative one between a patient and physician. The other is that the physician receives payment for services rendered, and how much is received has always been a matter of negotiation." But outside influences are threatening this relationship. "Today there are many external, primarily economic, intruders into this relationship. The dollar is still the primary issue, but it is no longer negotiated in a parlor between the physician and the patient."

During the final presentation of the morning, "The Academic Medical Center: Dinosaur or Dynasty," George E. Thibault, HMS professor of medicine, echoed the previous speakers, saying that research opportunities have narrowed since 1969. But at the same time that funding has diminished, the number of buildings that comprise HMS has continued to grow. And while HMS's white marble buildings, especially the MEC, illustrate the heightened stature of medicine, the academic medical center may be in decline. "Hospitals are not going to continue to be the centers of the medical universe."

The afternoon session, entitled "Personal Odysseys," was devoted to those alumni who, in the words of playwright Steven Sondheim (as quoted by moderator Donald Goldmann), chose to go "into the woods" of medicine, as opposed to "most of us who took the wide sunny road because we were told this was a safe course."

The afternoon session began with Donald Vickery who kept the audience entertained in David Letterman fashion as he discussed the triumphs and tribulations of the "Physician as Entrepreneur." Vickery is the chairman and CEO of Health Decisions, Inc., a service that provides support to physicians during difficult decision-making processes, by helping them assess the risks and benefits of potential treatments.

R. Joseph Petrucelli's career as a physician and art historian has been equally unusual. Petrucelli is the author of *Medicine: An Illustrated History,* which was published in 1978. His interest in combining the two professions began when Francis Moore '39 showed Petrucelli a first edition copy of Andreas Vesalius's *De Humani Corporis Fabrica,* produced in 1543. Petrucelli has studied both medicine and the history of anatomical illustration. His talk was supplemented by magnificent slides of Italian drawings, Peruvian sculptures and other historical artwork.

Of all the paths taken, David Fraser's may be the most surprising. For the past three years he has served as the head of the Social Welfare Department of the Secretariat de Son Altesse l'Aga Khan. His journey to this position was a long and varied one, which he described in his presentation entitled "Tradition and Transformation: A Physician's Continuing Education."

In speaking of his own unusual career, Fraser expressed a thought for his entire class: "Change is to be embraced, but at the same time managed."

Sarah Jane Nelson

Formula for Excellence

Personal, Professional, Institutional

by Mitchell T. Rabkin

MY ASSIGNMENT IS TO OPEN A DISCUSsion on excellence, and I want to focus on clinical excellence, since that is the first of several missions of Boston's Beth Israel as a major teaching hospital of Harvard Medical School. I propose to examine the evolution of the characterization of clinical excellence from unidimensional to a more solid concept to be thought of in three dimensions. For this, think in terms of solid geometry—of x, y and z—and not the three adjectives of my title—personal, professional and institutional—we'll get to them in a bit. And from there we'll move to health care reform and ethical dilemmas.

The x-axis. Not long ago, the definition of clinical excellence was an iconoclastic affair, with each physician deciding on the standards of his or her own performance. True, we read the literature—or some of us did. Others may have relied upon the detail persons from the drug houses. But in general, whatever way each of us arrived at our own standards of excellence, we probably labeled them "universal." More important was the fact that these standards were defined narrowly, typically relating to the technical aspects only of diagnosis and treatment. "Excellence" lay along one vector—call it the x-axis—and dealt with technical performance alone.

Today, our definition of professional excellence is less narrow, thanks in part to the contributions of Avedis Donabedian, who pointed out components of quality—the structure, process and outcome of the way care is given; in part to the studies of John Wennberg, who identified marked variations in practice among demographically comparable populations; and in part to Susan Horn, who underscored the importance of intensity of illness as a denominator in rendering judgments. But despite such sophistication in shaping these standards, to focus on the technical alone remains monocular. It is of prime importance, of course, but nonetheless a unidimensional approach to a three-dimensional issue.

It is the x-axis only of our solid geometry. Label this axis "PE" for professional excellence.

The y-axis. The issue of cost has become our constant companion, increasingly a determinant in the clinical actions we contemplate and take. Whether in the hospital, office or clinic, the notion of value is raised by those who pay for care—not necessarily value as the patient might define it, but rather value imputed for dollars expended. Out of this consideration emerges our y-axis, the second "PE," process efficiency. It relates to what we do as clinicians, the pathways by which these actions take place, their efficiency, and what they actually cost.

There is a natural happening I call "institutional rust" by which, over time, even the most efficient hospital process deteriorates in its cost and benefit considerations. After all, the world around any process changes so that the task it was originally designed to meet may have changed sufficiently to render that process outmoded. An example is the process set up for surgical admissions at a time when virtually all operations were on inpatients. Now, with more than half of our surgical inpatients entering the hospital on the day of surgery, via the OR, the old process for hospital admission has become outmoded, an example of institutional rust.

Most processes for patient care typically involve many departments of the hospital. For example, surgery involves not only the surgical service but also anesthesia, OR nursing, post-anesthesia care unit nursing, central sterile processing, transportation, admitting, environmental services, etc. Each department may be making adjustments to its own functioning in order to make its particular piece of the whole more efficient and effective, but the narrowly defined improvement for one department may deteriorate the efficiency or the effectiveness of the process as a whole.

A simple example might be a decision made downstairs that the supply carts to every unit will be identical in order to improve the efficiency of nightly restocking. But this would lead to a shortage of supplies on some units and on others, a loss through outdating. The result would be more phone calls, special supply trips, frustration and overall inefficiency. In today's environment, the notion of process efficiency has become a second dimension of excellence.

The z-axis. So far, we have a two-dimensional graph to characterize excellence, with professional excel-

lence on the x-axis and on the y-axis, process efficiency. What turns this into a three-dimensional construct?

It is not forced to find the third label with the initials PE. The z-axis refers to personal expectations. At Beth Israel Hospital, with support of the Picker Foundation and the Commonwealth Fund, we've been heading a project involving many hospitals in looking at aspects of care that can be evaluated only by learning how things appear through the eyes of the patients. You know the right dose of analgesic to prescribe, but only the patient can tell whether it was effective in relieving his or her pain. You know how to deal with postoperative care in the hospital, but only the patient can

tell us whether he or she was sufficiently informed to contend effectively with the recovery process at home. While it is true that not all patients' expectations can be met, nor necessarily should they, surely it is reasonable that one dimension of clinical excellence should relate to meeting the personal expectations of the patient.

But note, this third PE stands for personal expectations, not simply the expectations of patients. While the patient is of prime importance in the care process, many others are involved as well. Meeting the expectations of the physician falls within this dimension of excellence. After all, you invest a good bit of your lives in delivering patient care and it is reasonable that you should expect a return on that investment. And I don't mean simply in monetary terms; you have a right to expect that your hospital is reasonably responsive to your reasonable needs when trying to deliver the best possible care.

Hospital employees also have personal expectations: decent salaries, fair treatment, an opportunity to advance, a need to feel identified with the mission of the institution, and to know how their work fits into that mission. They, too, invest a major portion of their lives in this work and have a legitimate expectation of return. The same goes for the hospital's trustees, other volunteers, and for the entire community that supports the hospital. Each has expectations that warrant fulfillment along this z-axis, the third PE—personal expectations.

On all three axes, the changing economic environment has made its impact. Some would argue that personal and professional standards of the physician remain closely integrated, but institutional standards are increasingly vulnerable under economic pressures. The issue is even more exquisite, I would argue, if the physician has invested his or her own capital in the institution so that its success, in terms of return to the investor, may create major conflict with the otherwise altruistic standards of the individual caregiver.

Institutional representatives, on the other hand, might say that the restrictions under which they are obliged to operate in this new environment simply represent the necessary conditions to survive. They argue this is a world grown harsh—or merely realistic—through loss of unrestricted fee-for-service and cost-reimbursement, and survival is shaped by the market, that is, what the customer will pay for. Paradoxically, the patient receives the service, but the customer—in terms of who pays the bill—has become the insurer, the employer or the third-party payer.

This raises major strategic questions as well. Should the physician band with his and her peers in an economic aggregate that sees the hospital as a competitor for the payer's dollar? Or should the approach be that the individual, the profession and the institution are all in this together and, for the sake of the patient, should together work out a modus vivendi that does the best it can in an increasingly challenging environment? Isn't this particularly so for the teaching hospital, whose missions include scholarship as well as service? And for an institution such as Harvard Medical School, with more than one major teaching hospital, what is the appropriate pathway in today's market with respect to the dissonance between the academic advantages of interinstitutional cooperation and the divisive pressures of business competition?

Years ago, when I was in practice, one of my patients was my great uncle. At the end of each session, he would reach in his pocket and put two one dollar bills on my desk. "Uncle," I would say, "please, I don't want your money."

"Mitchell," he would reply, "relatives is relatives, but business is business!"

As a member of the Harvard Medical community, as a member of the medical profession, I am concerned whether we are being drawn into a vortex where "ethics is ethics, but business is business." If that occurs, where will be the excellence of Harvard Medical School tomorrow?

Excellence in medicine is an unending odyssey, and it is our privilege and challenge to be enmeshed in its stewardship. Let's hope as a profession we are up to the task.

Mitchell Rabkin '55 is president of Beth Israel Hospital, Boston and HMS professor of medicine.

What's in an Oath?

by Nathaniel Hupert

At the close of yesterday's graduation ceremony, my classmates and I voluntarily swore an oath that embodied some of our shared ideals about the kind of medical practitioners we want to be, and about the kind of profession to which we want to belong. It is a new oath, drawn in part from past medical oaths, both ancient and modern, but generated mainly from our visions of the role that physicians should play in contemporary society. We took very seriously the task of creating this oath, because we felt that in these times of heightened scrutiny of both the science and the practice of medicine, we should not underestimate the importance of a public display of the ethical commitments of its newest practitioners.

By "we" I mean the three of us who wrote the text earlier this spring,* and 100 or so of our classmates who ratified it, with minor alterations, on Match Day. Although our perspectives on the profession of medicine were informed by a diverse set of specialty and research interests, we shared a concern about the oaths from which we were asked to choose for our graduation ceremony. None of them appealed to us as an adequate expression of our ideals for future practice.

We felt the need to create a new document that would reflect the ethos of humane practice we had begun to explore in medical school. We viewed the process of writing an oath as an opportunity to articulate our ideals at the very starting point of our practicing lives, mindful of how forces external to those ideals—such as the influences of the market, government or society at large—tend to shape the character of our professional activities and sometimes threaten its integrity.

I would like to relate how we went about developing our new oath, and then close with some comments on why we feel the profession of an oath constitutes a vital first exercise of our professional voice as new physicians.

First, we sifted through four previous oaths: the so-called Hippocratic Oath (which we now know is really a Pythagorean religious tract written between the sixth and fourth centuries, BC); the so-called Maimonides Prayer (which actually was written in 1873 by the German physician Marcus Hertz); the 1947 Declaration of Geneva; and the oath written by the HMS Class of 1991, which has been used for the past three years. These texts served as a touchstone to our discussion of what we did and didn't want in ours.

For example, partly in response to the arcane wording of the Hippocratic and Maimonidean oaths, we tried to make our language as clear as possible, while still retaining the breadth and power of their central concepts. In creating the section on physicians' ethical obligations to individual patients, we looked at the nature of some of the most egregious past abuses of medical knowledge and also some of the most commonplace and banal, trying to word our oath with an eye to proscribing such actions. We then replaced the Geneva Declaration's phrase, "I will maintain the utmost respect for the sanctity of human life" with the phrase "I will not subordinate the dignity of any person to scientific or political ends." The latter, we decided, is more direct and appropriate, since those times when physicians subordinated human life to such ends, from Nazi Germany to Tuskegee and beyond, mark with infamy the worst episodes in our professional history.

From the Geneva Declaration we borrowed the notion of the political inviolability of the patient/physician relationship. This is a concept that Francis Weld Peabody '07 had earlier described as a beneficial type of professional "blindness." The Geneva document reads in part, "I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient." In our ver-

Oath of the Class of 1994

by the Oath Committee of the Class of 1994

**My collaborators were Lisa Harris, a future obstetrician/gynecologist who works with women who are victims of violence, and Sam Moskowitz, a future pediatrician who studies molecular genetics of mucopolysaccharide storage diseases.*

sion we shortened this to, "I will use my skills to serve all in need, with openness of spirit and without bias."

We chose to preserve several key features of the *Oath of the Class of* 1991: the dean's integral role as participant in the oath reading and the organization of the oath into four distinct parts, each representing a category of professional obligation. We felt that the dean should introduce the oath to explain its genesis and to acknowledge that the class freely chose to swear adherence to it in the public forum of the graduation ceremony. With these opening remarks, we sought to dispel some of the mystery surrounding the oath-swearing process, making it clear what we were saying and why we were saying it.

Like the *Oath of* 1991, ours was organized into sections that touched on obligations to individual patients, to community, to profession, and lastly to self. One difference was that while last year's oath placed duties to the profession before those to community, we reversed that order in ours.

Notably absent from our text are any references to God, gods or other religious figures. We decided that explicitly religious imagery or religious invocations were inappropriate in a communal statement of professional ideals, since the medical profession is no longer a priestly community and its practitioners have religious backgrounds as diverse as the communities they serve. Instead of asking for divine support, we thought it more fitting to focus on the secular issues of securing the public's trust in and support for the activities of the profession.

Finally, we decided to immortalize the collegial spirit of the New Pathway by pledging to advance the "humane education of future doctors" and to attend to our own health and that of our fellow practitioners. We left out the familial metaphors employed in other oaths to describe interprofessional relations, feeling that this more precisely covered the specific traits we wanted to encourage in ourselves and our colleagues. After all, if physicians swear to view their colleagues simply as family, there's always the possibility that they will, and that the family will be dysfunctional.

The question remains: why all the fuss? An oath is something that you mumble on your way out the door and vaguely remember as "Do no harm." Right? One prominent medical ethicist, Robert M. Veatch, has even claimed that the process of swearing

an oath adds nothing to a young physicians' ethical education that had not already occurred in the socialization process of medical school. Obviously, we disagree. There are many ways an oath can be significant. I would like to draw attention to the two I consider most critical.

First, the creation of an oath—by which I mean not only its writing by senior students, but also its discussion by the graduating class as a whole—

DEAN:
Today you stand before family, friends, teachers and colleagues, ready to become physicians and dentists. In closing this ceremony, you now, as a class, have the opportunity to articulate your commitment to these professions. The oath you have chosen sets forth ideals and principles to guide the work ahead of you.

Please take a moment to meditate upon these words, before reciting them together.

CLASS:
Now being admitted to the profession of medicine/dentistry, I pledge myself to the service of humanity. I recognize my obligation to serve my patients, my community and my profession. I will use my skills to serve all in need, with openness of spirit and without bias. The health and well-being of my patients will be my first consideration. I will hold in confidence all that my patients entrust to me. I will not subordinate the dignity of any person to scientific or political ends.

I recognize that I have responsibilities to my community: to promote its welfare and to speak out against injustice. The high regard of my profession is born of society's trust in its practitioners; I will strive to merit that trust.

I will promote the integrity of my profession through honest and respectful relations with fellow health professionals. I am indebted to those who have taught me the art and science of my profession and I recognize my responsibility, in turn, to contribute to the humane education of future doctors. I will strive to advance my profession by seeking new knowledge and by reexamining the ideas and practices of the past.

I assume these responsibilities knowing that their fulfillment depends upon my own good health. I ask that my colleagues be attentive to my well-being, as I will be to theirs. I will seek to improve my practice by addressing my mistakes and maintaining my skills.

I take this oath freely and upon my honor.

A Cautionary Conjecture

(Based on 25 years of medical center metamorphosis, by Bruce McLeod '69)

Go back to Longwood. Look around.
Whatever happened to fair Harvard?
It's Brighamed! Womened! Dana
Farbered!
There's even parking underground!

And what I read is past all reason,
That to this crowd panoply
For greater cost efficiency
The MGH will somehow squeeze in!

It's much the same where I reside
(Though we have never been BIed).
Construction at a frantic pace
Spread over every inch of space
When all the beds were occupied.

Now those new doors stand open wide-
But not for patients coming in.
Depart! all ye whose jobs have been
Cut back to stem the stubborn slide

In bottom line and length of stay.
This is a most disturbing trend;
One wonders where it all will end.
Restructurers may one day say

That, with correct administration,
A vast expanse of brick and steel
Itself could render care, and heal,
And do research and education,

And howsoever loud the crying,
No one but a volunteer
Need ever venture very near
The anguish of the sick and dying.

Here's the cautionful conjecture:
The time will come when any fool
Who enters Harvard Health Care
School
Will study only architecture.

offers medical students the opportunity to reflect critically on the ideals they want their profession to strive toward and the virtues they think they should cherish in themselves and in their colleagues as members of that profession. Second, the oath is our first communal professional voice as physicians. With it, we tell the world what we as physicians are about, where we are headed and what kind of a professional world we want to build there. Our society expects this of its healers, especially now that medicine and health care are so much in the public mind. In this sense, it is our duty to take care with what we pledge on our honor to a life in the profession. We might be taken at our word.

Both of these points have complicating elements. While many in our class helped to create the oath, no one checked to insure that every graduate stated it. One always has the option of exit: "I never swore to that." In turn, not all medical schools use the same oath—certainly no others used ours this year. Clearly, as oaths are concerned, there is no one voice of the profession, but a multitude of competing voices. In this way, oaths reflect the nature of the profession, in part tradition-bound, in part self-consciously contemporary and innovative.

The choice to swear an oath and the choice of oaths to swear are both elements of the professional voice that new graduates of medical schools have to exercise—in other words, a critical element of that voice is the choice to use it, because its silence can be deafening. Two hundred years ago the patriot physician Benjamin Rush urged that physicians "should disdain an ignoble silence on public subjects."

Fully aware that our livelihood is now a public subject, we, the Class of 1994, decided to start out on a speaking foot.

Nathaniel Hupert '94 is doing a residency in primary care at the University Health Center in Pittsburgh. His collaborator in writing this talk is Alice Crary, PhD candidate in philosophy at the University of Pittsburgh.

Adolph Gundersen '49 shows the history of his family's medical legacy to Robert Stone '34 and Stanley Garber '34.

The Women are Back

Sharon Murphy '69, Tenley Albright '61 and Wendy Clough '68 talk at the reception before the women's dinner.

Following on the heels of Coleus Society reception was another just across the way in the Alumni Atrium in Building A. The women's dinner, resurrected after a five-year absense, was an energetic conflux of alumnae and female students. "There was an overwhelming response," said Elena Martinez '97, who helped organize the event and who contacted all the female graduates about becoming mentors. "That's very exciting."

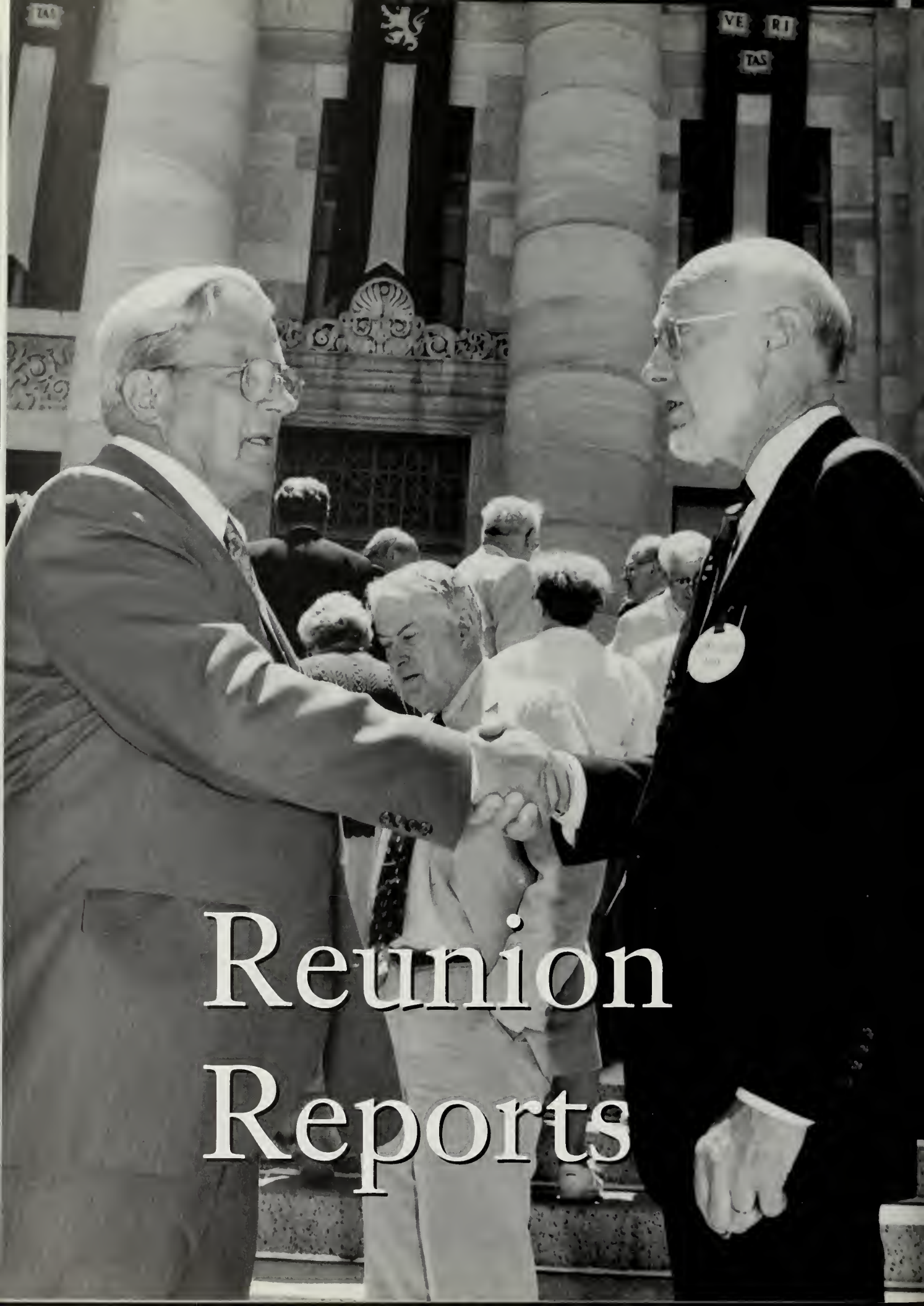
While there was a lot of energy and goodwill as returning graduates in all stages of their lives and careers spoke with the many students attending, a tinge of opposite emotions was present as women remembered their endeavors to forage a place for themselves in a male-dominated profession. "You just listen to their stories to see how much they had to overcome," said Debbie Cheung '97. Wendy Clough '68 affirmed the younger woman's sentiments: "I've had some tough experiences, but [I hope] it helps women now."

Stephanie Pincus '68 moderated a dinnertime panel of alumnae and students who talked about their lives, both professional and personal, and about their visions of the future. Lara Goitein '97 eloquently brought the past, the present and hopes for the future together in a story of her mother, who in the 1960s was one of only seven women in her medical school class. She was told by a male classmate she should be a nurse. "Men in my medical school class would say that women have the right to any walk of life," said Goitein.

Thankfully Goitein's mother, Marcia Angell, eschewed her classmate's advice and went on to become the editor of *The New England Journal of Medicine*. "You were our trailblazers," said Goitein.

Terri L. Rutter

Future alumnae Elena Martinez '97 and Lara Goitein '97 helped organize this year's dinner.



Reunion Reports

62ND

AT THE 60TH REUNION OF THE CLASS of '32 (in 1992) it was noted that the Alumni Office did not take official cognizance of 65th reunions. This was not unreasonable, as almost all members of such a class would be nonagenarians. However, longevity has increased substantially; it was voted to try a 62nd. Since then five classmates have passed beyond, but we believe there are still some 28 survivors.

As the year progressed, we boldly tried a 62nd and succeeded after a fashion. Our class was listed first (as the oldest) in the alumni week program. Class president Claude E. Welch and Seebert J. Goldowsky attended the Alumni Day activities on June 10. Our class was called up first for the class photo. Welch and Goldowsky stood alone, firmly representing the class.

Five members of the class and four spouses attended the reunion luncheon, which was held at the Harvard Club of Boston on June 11. We were served a delicious traditional New England meal of clam chowder, broiled Boston scrod and Boston cream pie. Welch presided. It was recalled that our 60th reunion had been dedicated to the class's favorite teacher, the late Robert ("Bobby") Green. We dedicated this reunion to our late illustrious classmate, Carl W. Walter. We were delighted that his widow, Margaret, was able to join us.

Our guests were Richard and Elin Wolfe. Wolfe is curator of rare books and manuscripts of the Francis A. Countway Library of Medicine, Joseph Garland Librarian of the Boston Medical Library, and one of the world's leading authorities on marbled book endpapers. He is also author of several scholarly books. Wolfe shared with us his colorful reminiscences of the Class of '32, which he rates as the second most distinguished class of HMS. He said it is exceeded only by that of the immediate post-Civil War period, which boasted a distillate of brilliant veterans recently discharged from service. He singled out the late Mark D. Altschule, his close associate at the Countway, and also mentioned among its brighter stars Henry K. Beecher, David G. Cogan, Lester King, August S. Rose, Wesley W. Spink, Carl W. Walter and Claude E. Welch.

All present considered the event a warm and charming experience. Everyone voted unanimously to canvas the class in 1995 to determine whether a 63rd is desired and feasible.

Seebert J. Goldowsky '32

Adolph Gundersen '49 catches up with Arthur Garceau '54 on the steps of Building A.

60TH

IT WAS A LOVELY TWO DAYS OF SUN and warm weather, much appreciated, for our 60th. An interesting three-year cyclic pattern of deaths in our class ('87, '90, '93) gave us a warning that the reunion would not be heavily attended. But, indeed, a dozen (30 percent of those still above ground) came at least to the Friday morning program and the evening festivities. The Alumni Office graciously provided us with a shuttle van, which ran between the Children's Inn to the tent on the Quadrangle, and was a boon to those dependent upon wheelchairs. We were inspired not only by the words from the dais, but also from the returnees, particularly our colleague from the Class of 1924, Merrill Greene. We were impressed by the oath prepared and taken by the graduating class of 1994.

That evening, in the warm ambiance of the Estabrook Room in the Harvard Club, we enjoyed four hours of food, memories of past classmates, teachers and events of those days. Syd Stillman spoke of his experience helping care for Hans Zinsser in his last months and then read his "Sonnet on Impending Dissolution." John Dziob again amazed us by quoting extemporaneously from Shakespeare for 14 minutes. It was long past our usual bedtime when we broke up.

Saturday, June 11 had more blue skies as we took a launch trip on the Charles River. After a short delay we chugged upstream with wonderful views of the back side of the city, past MIT and Harvard College. Nearing Watertown a black cloud appeared ahead so we ate lunch and turned around. It was a pleasant trip until disembarkation once again thrust us into Boston's traffic. All enjoyed the reunion, but felt we had been wise to have our mini-reunion between the

55th and 60th rather than after the latter. The cyclic pattern of demise mentioned above helped us in that thinking.

Thomas A. Warthin '34

55TH

ACCORDING TO THE MOST ACCURATE tabulations, there are 65 surviving members of the Class of '39, which had graduated with approximately 130. The class mustered 25 members and 20 wives for our 55th anniversary reunion. Though early in the planning stage there was some concern that there would be little enthusiasm for another get-together, it was unanimously agreed by all who came that it was a most worthwhile and successful occasion.

We all enjoyed being with one another and the status of the people there was impressive. Most of us spent Thursday attending the 25th-year reunion symposium from the Class of '69. It was extremely stimulating, both in the morning and afternoon.

On Thursday evening Arthur and Anna Pier entertained us at their Brookline home with cocktails and a buffet supper. On Friday we were all inspired and challenged by the Alumni Day exercises on the Quadrangle and the masterful performance of Dan Federman '53 as moderator. It was also a welcome opportunity to see old friends from other classes.

Friday evening we returned to Vanderbilt Hall for dinner in the Common Room, followed by a special program of entertainment, which included a performance of a string quartet organized by Jean Stanbury and a delightful talk with illustrated slides depicting important HMS alumni from revolutionary times to the present. We then sang some wonderful songs accompanied by Franny Moore, who could have made his way at a supper club in New York if he hadn't been such a good professor of surgery at HMS.

Saturday was another picture perfect day in New England, and we journeyed by bus to tour Plimouth Plantation and then to Marion to the home of Franny and Kathy Moore. There we had a fine catered lunch and the opportunity to relax, reminisce and renew the friendships that have bound us together over the last 59 years.

We parted having missed those who were not with us; somewhat sobered by the realization that some who were here might not make it for our 60th, but grateful to all who came, many from long distances, to make this a happy and memorable reunion.

Daniel Sumner Ellis '39 *and Eben Alexander Jr.* '39

50TH

THIS WAS ONE TO REMEMBER. HALF the class—some despite illness and disability—came for some part of the celebration: the reception at Vanderbilt Hall or the dinner in the Medical Education Center, where Dean Dan Federman '53 brought us up to date on HMS and Alumni Day. It was a grand get together, seeing friends and getting reacquainted with classmates whom we may not have seen in years. It was a chance to visit old haunts in Boston and to revive memories of the best sort.

We noted proudly the class gift of over $115,000 in which more than 80 percent took part. We were grateful for the help of Hope Wigglesworth in encouraging several widows of classmates to come, and especially grateful for their generous contributions to the Alumni Fund.

Many went for a warm, relaxed weekend at the Stage Neck Inn in York Harbor, Maine. Here Dick Olmsted chaired a reminiscence session, where we learned of Earl Holt, the bugler, who played "Abandon Ship" every morning instead of "Reveille." We discovered that Bill Faloon had a brief and lucrative professional basketball career (total income, $5.00), and that Keith Merrill had treated a complex case of heat exhaustion on Crete, despite primitive conditions, little Greek, and certainly no license. Bob Pfeffer recalled Captain Fairbanks hiding near the door of Vanderbilt Hall to catch stragglers after curfew.

We were entertained by Keith's trumpet and Hank Bahnson's virtuoso harmonica. In addition to playing old favorites, Hank approached the instrument with an historical and structural view. (What else would you expect of an HMS trained professor?) The consensus is that this was the best reunion ever. Some are already planning for the 100th!

Chester d'Autremont '44

45TH

THE CLASS OF '49'S 45TH WAS A great and heart warming occasion. At Thursday's symposium and luncheon, groups of classmates began to gather. Dinner at the Harvard Club was fun and a relaxed opportunity to adjust to the changes of the years. Deceased classmates and those not present were affectionately remembered and friendships reinvigorated.

Friday we had an opportunity to exchange thoughts on medical education and medicine in a more formal way at the Alumni Day program and luncheon. The dinner cruise of Boston Harbor turned out to be a dramatic and fun way to see the big changes in Boston's skyline.

Saturday was capped off by a seaside clambake in Nahant, hosted by the genial Kellers. The reunion again revealed that HMS continues to carry on its quality work despite the growing challenges. And, of course, '49 remains the best bunch of all.

Here's to an even bigger bash at the 50th. Suggestions are requested.

Morgan Vigneron '49

40TH

CONSISTENT WITH THE CLASS OF '54'S 40-year performance, the class turned out in much higher percentage than any previous class. There were 110 at the excellent dinner Thursday night at the St. Botolph's Club. Over the weekend 110 showed up at the Weekapaug Inn in southern Rhode Island. Again, the accommodations, food and weather were excellent. The chemistry that binds this class is a mystery but the every-five-year warmth and solidity is manifest.

John Vorenberg '54

35TH

WE ARE NEARLY ALL THE SAME AGE and have thus shared most of life's milestones, and we were very, very close in medical school, both in the physical sense (say, struggling together while hovered over our cadavers), as well as emotionally. This does not fully explain to me why this class comes together with such intimacy and ease at our reunions. We all take such pleasure in renewing our friendships, catching up, learning something new about people whom you figured you knew just about everything.

Members of the class showed up from all points in the country: Dixons and son from the deep South, Sandersons and Burkhardts from the southwestern desert, Epstein's from San Francisco (it was wonderful to see that Charlie and Lois have regained control of their lives after the grotesque bombing that cost Charlie much of the use of one hand) and Urquharts from everywhere (would you believe California and Holland?). We were very much aware of our most recently lost classmates: Sally Howell, Kitty Kris and John Dowling, who were all very much with us in spirit.

We were treated to an elegant and generous buffet at Don and Phoebe Giddon's on Thursday, had our silly picture taken during Alumni Day on Friday, and enjoyed a fine dinner at the newly ambitious Faculty Club in Cambridge (no horsemeat). Saturday night we went off to Brewster. Lots of fun, but it was beyond my power to screen out the distractions of the world as the adjacent bar emptied between 1:00 and 2:00 in the morning.

Generalizations:

There has been more change in perspective over this last five years than in any since graduation. Many of us are cutting back or changing work and leisure activities, and the rest seem to be thinking about it.

There has been a shift in values. Our inner sense of self-worth has less to do with career than other priorities: family, religion, society, avocations, whatever.

Many of us have been through the mill: corrupt, or at best unappreciative, behavior from our employees; hard losses, from death or divorce; difficult illness or injury. Still, I certainly had the sense of unflagging spirits, of the pleasure and strength we drew from each other. It was a good and necessary time.

David Rush '59

30TH

THIRTY YEARS? CAN'T BE. BUT SOME 50 class members—and almost as many spouses—joined in this reunion, blessed by June-perfect New England weather. It began Thursday evening at a reception in Weston at the house of host and class agent, A.W. Karchmers. The evening featured good conversation, the presence of a classic New England stone wall (a marvel to the Californians), and a striking reversal of last-name grouping as six of the nine Bobs in the class surprisingly found themselves constituting a conversation group. There were bountiful hor d'oeuvres and the beginning of a medical school slide show. On Friday evening, after smilingly murmuring "Circle of Tugo" for the class photograph on Alumni Day, we gathered at Frank Lloyd Wright's place, the American Academy of Arts and Sciences building in Norton's Woods in Cambridge for the class dinner.

We continued to renew friendships and catch up on lives. Not to be outdone by the architecture, we embarked on a course of impromptu speeches at the dinner, some of us waxing (and waning) philosophical on the state of our particular subspecialty (infectious disease was multiplying), on foundations, on managed care and on Harvard. Others kept things humorous. The Jackman slide show continued, from the great Vanderbilt fire and graphic first-year anatomy, on through various of our adventures (second-year show) and misadventures (guess). (Public notice: at the 35th, everyone is encouraged to present his/her own view of the most memorable HMS '64 nostalgia in five or so slides—was there a defining moment of HMS '64 or was it rather a course of Kierkegaardian persistence?)

Saturday we ambled through the Endicott mansion and its grounds, talking, croqueting, drinking, playing tennis and thinking how well the builder had used the Endicott Johnson Shoe company fortune. We then got down to the serious business of a vintage New England clambake, including multiple lobsters and multiple sundaes for those who dared.

What were we like now some 30 years later? Mellower, for the most part and very satisfied with our own careers and lives. Though we recognize that the world of medicine is changing and that our profession hadn't taught us about its economic aspects. We thought about our classmates who have died, and were very pleased that Barbara Latt and daughter could join us on Saturday. We wondered how things were for our classmates who couldn't attend, and telepathed greetings, while wishing openly that those of you reading this who weren't there, could have been. Mark your calendars for the end of the millennium—the 35th reunion in June 1999.

Robert McCarley '64

25TH

THE CLASS OF '69 RETURNED IN large numbers for the 25th reunion. We were blessed by spectacular weather that was exceeded only by the warmth and camaraderie that we all felt with one another.

Barb and I were pleased to host the kickoff event at our home on Wednesday evening. On Thursday the class symposium represented a wonderful mix of science, reflections on medical practice and personal stories. In addition to the nine class speakers and three class moderators, many other class members in the audience offered their insights and personal experiences. We also were gratified by a very large attendance by other alumni and friends. Thursday night we had a wine tasting dinner at Cornucopia on the waterfront, with spectacular harbor views.

On Friday we had the pleasure of giving one of the largest 25th reunion gifts ever. This was particularly important because 100 percent of our gift will be allocated to student aid. We then had the pleasure of watching Dan Federman '53 weave his magic as moderator of the symposium on health care reform and ethical issues in the '90s. Friday night we had an elegant dinner at the Fogg Museum. We were transported by the setting, the string quartet and the fine food and wine; a night we wished would never end. On Saturday we had a perfect finale with a clambake at Steve Kanner's home in Concord, including tennis, canoeing on the Sudbury River and lots of time for relaxed conversation with classmates, spouses and children. In all, 65 members of the class attended at least one of the functions.

It is difficult to summarize in a few lines the hundreds of hours of wonderful conversations that ensued. In general the mood was upbeat. Most people feel very good about their personal and professional decisions,

although there is much concern about whether those who follow us will have the same opportunities and gratification that we have felt. On the whole we have mellowed in a very positive way. The pursuit of excellence still burns strongly, but this has been tempered by an appreciation of our limitations and a greater appreciation of family and other personal pursuits. We departed with promises to keep in touch and to meet again in five years.

George Thibault '69

20TH

EARLY ARRIVALS AND A FEW "TOWNies" gathered Thursday evening at Bob Kirkman's apartment at the Flagship Wharf condominium complex in the former Charlestown Navy Yard. The balcony, with a splendid view overlooking the harbor, provided the setting for cocktails, light banter and the easy renewal of friendships lapsed over 20 years of time and distance.

The following day, more formal festivities were planned for all the returning classes on the Quadrangle. Circling the field prior to landing, your class agent noted that these activities had all the premonitory signs of risking potential exposure to hazardous materials (educational content, fundraising, etc.), as well as requiring a coat and tie for proper attire. Shocking, really. Prudently, your truant correspondent diverted the mission to an alternative landing zone, instead choosing to escort his 13-year-old nephew to the anatomical museum at the top of Building A. Then a quick stop at the Medical Area Coop before repairing to a watering hole in the North End for an evening of intimate conversation and wretched gastronomic excess in the company of C. Herbert Yorke Jr. and his family, Mary Powell, Zack and Chris.

Saturday was idyllic. A magnificent clambake/lobster supper was convened by David Koh at his bluff-side compound in Marblehead. The beach below provided entertainment for the kids, and the ocean vista supplied the backdrop for an open-air concert by Dave and Bob Stark, who reprised some of their greatest hits of the '60s and early '70s, including an electrifying rendition of the class anthem, "Gloria," which provoked vast amusement in the son of Dr. G. Singleton-Gaston of Marietta, Georgia.

We adjourned, in dribs and drabs, with vows to do this again in five years. Shared an enjoyable conversation riding back to town with Mitch a.k.a. "MAD" Max, road warrior. We got lost in Brookline as darkness descended to end a perfect day. All over and much too quickly.

Tim Russell '74

15TH

THE CLASS OF '79 GREATLY ENJOYED their 15th reunion dinner at the Colonial Inn in Concord and their afternoon cookout in the very excellent backyard of Jean Ryan. Thank you Jean and Tim for your hospitality and tolerance!

Everyone seemed to enjoy catching up with old classmates. Our children painfully tolerated countless introductions and graciously allowed us to show them off to each other. Beautiful babies abounded. (In the "best cheeks" category, the award goes to Andy Bauman's daughter; "incredibly cute" to Ann Rixinger's baby Steven.) Rhonda Rand's two lovely little ladies enjoyed themselves despite jet lag; Neal Scott's very beautiful little daughter appropriately ran away from Jim Kirshenbaum when he approached her. (Still got a way with the ladies, Jim.)

Old friends got together and gossiped—is what Andy Satlin said about Paul Yock really true? Next time Paul, you really better bring your wife. Mel Gonzalez, Bill Rigby and Chris Doyle looked like they were ready for a football game on the Quad or a romp through Vanderbilt halls, but John Ingard and look-alike sons were too tired out from multiple soccer games to join in.

It could have been the summer of '78. Leona Brenner, Liz Woods, Barry Tortella, Dan Rome, Cheryl Warner, Dave Cochran and John Chin looked very much the same except for some slightly changing hair colors. (Leona's is darker these days, don't you think?) But, how is it that Dea Angiolillo keeps looking younger? Leo Troy's body looked especially impressive, and Tom Sterne looked wonderful and sounded so wise (but still, happily, with a good dose of wise-guy there). Ed Supple, while still very handsome was awarded "least recognizable," with a second in that category to John Warbritton.

Our class politicians and medical leaders were there (Richard Rockefeller and Deborah Prothrow-Stith), and confirmed that medicine will never be the same. Marlene Krauss continues to enjoy her CEOship. (Sounds like she still has some of the best ideas on the field of medicine to pursue.)

Kudos to Anthony Van Niel for being a superb reunion chairman, and for spending the most time in the pool at the cookout. Thanks to the reunion committee for all their time and energy as well. Thanks to Anne St. Goar for taking our money, to Jean Ryan for the cookout, to Mary Hoyt Briggs for organizing Friday night, and to Andy Satlin for the gossip.

And to those who despite being departmental chairmen couldn't get the weekend off (Mike Hirsh) or were traveling across some far off continent (Liz Kincannon), you missed a nice visit with old friends. Try to make it next time. See you at the 20th!

With best wishes for a happy and healthy next five years to us all.

Sue Witkie '79

10TH

THE CLASS OF 1984'S 10TH REUNION was a tremendous success, with a good turnout and a lot of fun. Nearly 70 people participated, including husbands, wives and children. We had already had a very good response to the questionnaire compiled by Rick Mitchell and Joe Glenmullen, which they published as our "Reunion Report," including some very interesting profiles. (It is still unclear whether the "last book read" being *Cat in the Hat* meant that the person had just put their child to bed before filling out the questionnaire or whether academic

and medical life has prevented any recreational reading for the past 35 years.)

The events began on Thursday evening, with a dinner (sans children) at the Peking Garden restaurant in Lexington. About 45 of us filled the back room, which was also soon filled with catching up and some great Chinese food (good idea, reunion treasurer Michael Chang!). The Friday lunch and official photo session was a smaller affair. The biggest event found us under a tent—which fortunately protected us from sun rather than rain—in the yard at our home in Wellesley, where a delicious barbecue was (eventually) produced. Toys, including balls and Frisbees, kept about 15 children happy while we all compared notes on the diverse courses our lives have taken in the last decade.

Honors for traveling the farthest go to Erik Gaensler (San Francisco), who in "class(Er)ik" fashion fit about 18 social events into a two-day trip, including our HMS 10th and his 15th Harvard College reunions.

On behalf of the entire Class of 1984 I would like again to thank the reunion planning committee, and especially Rick and Joe for compiling the questionnaire and report. Thanks to Michael for "balancing the budget." Perhaps our 15th can include a few numbers from our second year show; (how distant a memory is the Pre-Cynical Years for YOU?)

Edward M. Hundert '84

5TH

THE CLASS OF 1989'S FIFTH-YEAR reunion was held at the Harvard Faculty Club in Cambridge. About 20 classmates with their significant others attended. Dinner conversations focused on family and careers. Many had just taken their first job following residency. There were those in private practice and those who stayed in academics. A fair number were still training, either still finishing residency or starting a new residency or fellowship. Everyone seems happy with what they are doing. There were enough classmates at the reunion who knew what other classmates were doing that by the end of the evening, almost everyone had been updated as to the whereabouts of the Class of 1989. Family was a major topic of conversation. Many classmates had one or several children. The wonderful time continued the following day. Dean Daniel Federman '53 graciously hosted a barbecue at his house. The food was wonderful. In all, the weekend was a great opportunity to remember medical school and take a look back at how far we had come in five years. I look forward to seeing as many of you as possible at the next reunion in 1999.

Domenic Zambuto '89

Alumni Notes

1928 **David E. Liston:** "I will be 94 in August 1994. Living in a retirement home in Sarasota, Florida for the past nine years. I'm a widower with one daughter and an increasing number of grandchildren."

1932 **Seebert J. Goldowsky:** "In May 1994 the newly organized HMS Club of Rhode Island held its first annual luncheon meeting at the University Club in Providence. It was attended by 23 alumni, spouses and guests. According to the Alumni Office there are some 80 graduates in the Rhode Island area. **Daniel Federman '53**, dean for medical education, addressed the group, describing in stimulating and informative fashion recent developments in education at the medical school. It was a beautiful spring day, the meal was delightful, and the good fellowship was apparent. It was a hopeful beginning for this fledgling organization."

James S. Mansfield: "Retired in Lincoln, Massachusetts. Son Frederick is another orthopedic surgeon at Massachusetts General Hospital."